

Remained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11331  
Item 13 & 7 fil 12 02-98 10/25/61 iwk  
11316  
MAYLAND  
11331  
11316

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		d. STREET ADDRESS <i>Amara St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Elizabeth</i> Last <i>Barwick</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>18</i> Year <i>1961</i>		5. SEX <i>F.</i>		6. COLOR OR RACE <i>W.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Apr. 5 1871</i>		9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>13</i> Hours <i></i> Min. <i></i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Barwick</i>	
14. MOTHER'S MAIDEN NAME <i>Mary E. Graham</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Harold Barwick</i>		Address <i>Frederick, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO (c) <i>arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days -</i> <i>20 yrs.</i> <i>20 years</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral deafness</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>4-24</i> , 19 <i>61</i> , to <i>10-18</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>10-17</i> , 19 <i>61</i> , and that death occurred at <i>15M</i> , from the causes and on the date stated above.		22a. SIGNATURE <i>Harold B. Plummer</i>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>Harold B. Plummer</i>	
22d. ADDRESS <i>Preston, Md.</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Oct. 21, 61</i>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Easton Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. ...</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 23 61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

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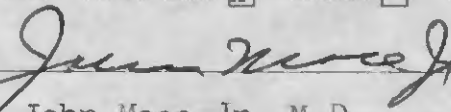
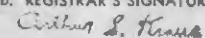


**FOR STATE  
HEALTH DEPT.**

11332

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11317

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester Co.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crocheron, Md.</b> c. LENGTH OF STAY IN lb <b>42 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crocheron, Md;</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crocheron Md.</b> d. STREET ADDRESS <b>Crocheron, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Sarah Elizabeth Bennett</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>Oct. 16, 1961</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Dec. 27, 1872</b>
<b>9. AGE</b> (In years last birthday) <b>88</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min. <b>None</b>	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>12. BIRTHPLACE</b> (State or foreign country) <b>Holland Island, Md.</b>	
<b>13. FATHER'S NAME</b> <b>George Waller</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Waller</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>Milton Bennett</b>		<b>18. ADDRESS</b> <b>Crocheron, Md.</b>	
<b>19. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <b>30 Mins.</b>			
<b>21. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>22a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>22b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>23a. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. _____ 19	<b>23b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>23c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>23d. (City or town)</b> (County) (State) _____
<b>24. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b>  <b>EXAMINER'S NAME (Type)</b> <b>John Mace Jr. M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>10/19/61</b> <b>Address (Street, city, town, or county)</b> <b>Cambridge, Md.</b>	
<b>25a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>25b. DATE THEREOF</b> <b>Oct. 18, 1961</b>	<b>25c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenlawn Cemetery</b>	<b>25d. LOCATION (City, town, or country)</b> (State) <b>Cambridge Md.</b>
<b>26. FUNERAL DIRECTOR</b> <b>LeCompte Funeral Service</b>		<b>27a. REC'D BY REGISTRAR</b> <b>Oct 24 1961</b>	
<b>27b. REGISTRAR'S SIGNATURE</b> 		<b>28. ADDRESS</b> <b>Cambridge, Md.</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**11333**

**11318**

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>		c. LENGTH OF STAY IN 1b <u>22 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hurlock - Shiloh Road</u>				d. STREET ADDRESS <u>/ Hurlock - Shiloh Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Milbourne</u> Middle <u>Brewington</u> Last <u>Brinsfield</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 1, 1893</u>		9. AGE (In years last birthday) yrs. <u>68</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Brinsfield</u>				14. MOTHER'S MAIDEN NAME <u>Cleo Hurley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-28-8344</u>		17. INFORMANT Address <u>Mrs. Katie E. Brinsfield, Hurlock, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>atherosclerotic Heart Disease</u> DUE TO (c) <u>Essential Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH. <u>10 min.</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>  </u> <u>  </u> p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <u>  </u> Not while <u>  </u> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 29, 1960</u> to <u>Oct. 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 21, 1961</u> and that death occurred at <u>10:30</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Jason F. G. Yee M.D.</u>		22b. ADDRESS <u>Hurlock, Maryland</u>		22c. DATE SIGNED <u>10-23-61</u>			
22a. PHYSICIAN'S NAME (Type) <u>JASON F. G. YEE M.D.</u>		22b. ADDRESS <u>Hurlock, Maryland</u>		22c. DATE SIGNED <u>10-23-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 24, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

RECEIVED  
JUN 14 1914



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G297 10/16/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No. **11319**

**11334**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester Co.</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Dorchester Co.</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>			c. LENGTH OF STAY IN 1b <b>70 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Md. Hospital</b>				d. STREET ADDRESS <b>Cambridge R.F.D. # 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Omar</b> Middle <b>B.</b> Last <b>Brown</b>				<b>4. DATE OF DEATH</b> Month <b>Oct.</b> Day <b>8,</b> Year <b>19 61</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 10, 1961</b>	
<b>9. AGE</b> (In years last birthday) <b>76</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Furniture Refinisher</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Furniture Repair</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Kent Island Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Jashua Brown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ella Bridges</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> <b>Mrs. Kenneth Lyons</b> <b>1345 U St. SE, Washington, Dc</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY DISEASE 2 DAYS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a. m. _____ p. m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>3/2</b> , <b>1959</b> , to <b>10/8</b> , <b>1961</b> , that I last saw the deceased alive on <b>10/8</b> , <b>1961</b> , and that death occurred at <b>6:15 P.M.</b> , from the causes and on the date stated above. <b>W. E. GUNBY JR.</b> M.D. <b>105 CHURCH ST</b> <b>10/10/61</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>W. E. GUNBY JR</b> <b>CAMBRIDGE MD.</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>Oct. 11, 1961</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Dorchester Mem. Park</b> <b>22d. LOCATION (City, town, or county)</b> <b>Cambridge, Maryland</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>LeCompte Funeral Service</b> <b>Cambridge, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE OCT 13 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Wm. S. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, page 1, and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

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Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1886		Maryland	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Artery Disease		Natural		Farmer	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 15, 1931		10:30 AM		Home		Dr. J. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	





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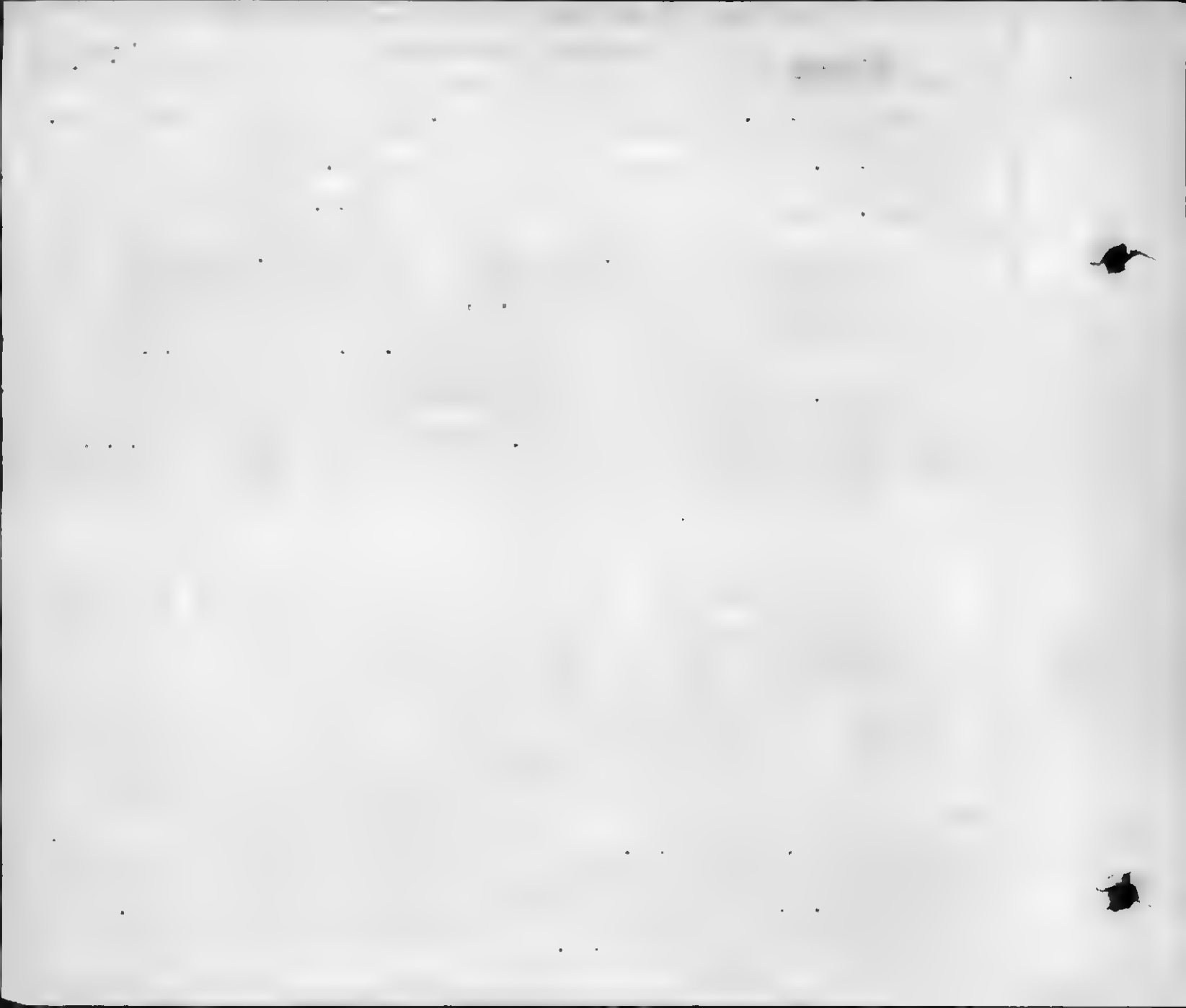
## CERTIFICATE OF DEATH

Reg. Dist. No. 11321

11336

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester, Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hills Point, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Md. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Beatrice</b> Middle <b>V.</b> Last <b>Condon</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 5, 1910</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Neck Dist. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>William H. Condon</b>			
14. MOTHER'S MAIDEN NAME <b>Mamie Woolen</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs. Robert Marshall</b> Address <b>Cambridge R.F.D. # 3</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Chronic nephritis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic mellitus, mental retardation</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Oct. 13</b> , 19 <b>61</b> , to <b>Oct. 30</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Oct. 30</b> , 19 <b>61</b> , and that death occurred at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Albert E. Bunker</b>				ADDRESS (Street, city or town, state) <b>200 Maryland Ave., Cambridge Md 21613</b>			
DATE SIGNED <b>Nov 16, 1961</b>							
PHYSICIAN'S NAME (Type) <b>ALBERT E. BUNKER, M. D.</b>				<b>CAMBRIDGE, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 1, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>East New Market, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 7 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11337

CERTIFICATE OF DEATH

11322

1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN lb <b>344 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS <b>Rural</b> <b>C7X</b>	
3 NAME OF DECEASED (Type or print) <b>ANNIE CORRIDEAN</b>		4. DATE OF DEATH <b>Oct. 30 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-21</b>
9. AGE (In years last birthday) <b>90</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>REED, Thomas M.</b>		14. MOTHER'S MAIDEN NAME <b>HARRIS, Rachel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS IRENE MERREY</b>		Address <b>ELKTON, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> <b>50.0</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>LEFT SIDED HEART FAILURE</b> DUE TO (c) <b>ATHEROSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>3 YEARS</b> <b>7 YEARS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DEHYDRATION &amp; INANITION</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>7-19 1958 to 10-30 1961</b> , that (I) ( <del>not</del> ) last saw the deceased alive on <b>10-30 1961</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Geo M. Dunn</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>GEO. M. DUNN, M.D.</b>		22d. ADDRESS <b>EAST. SHORE STATE HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/2/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Elkton MD</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M. Reed, Rising Sun, Md.</b>		25. REC'D BY REGISTRAR <b>DATE NOV 1 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>C. J. Harris</b>	





11338

CERTIFICATE OF DEATH

11323

1 PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>E.S.S. Hospital</u>		d. STREET ADDRESS <u>X</u>	
3. NAME OF <u>Florence</u> First <u>Dublin</u> Middle Last		4. DATE OF DEATH <u>October 24</u> 19 <u>61</u> Month Day Year	
5 SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>---</u>	
17. INFORMANT <u>E.S.S. Hospital Records</u> Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis with C.V.D.</u> DUE TO <u>2002.425</u> (c) <u>with cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u> (b) <u>---</u> (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>October 3, 1961, to October 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>October 21, 1961</u> , and that death occurred at <u>8</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Simon Virkutis</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>SIMON VIRKUTIS</u>		22d. ADDRESS <u>E.S.S. Hospital, Cambridge, Md. 10/22/61</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>10/25/61</u>	23c NAME OF CEMETERY OR CREMATORY <u>Westview</u>	23d LOCATION (City, town, or county) (State) <u>Cambridge Md</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill Ind.</u>		25a. REC'D BY REGISTRAR DATE <u>24 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Walter S. Kline</u>	



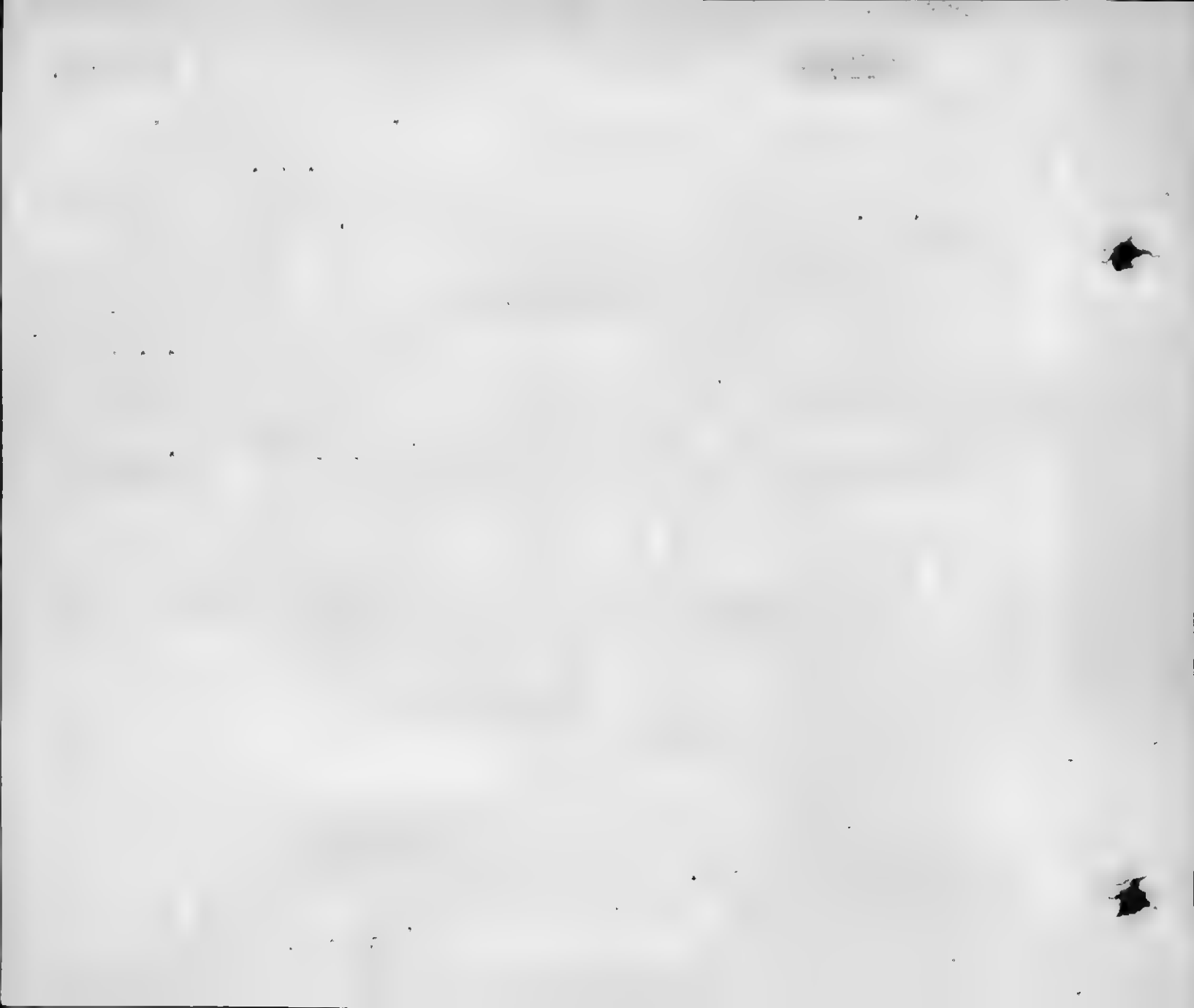
**FOR STATE  
HEALTH DEPT.**

11339 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11324

- |   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Dorchester</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Dor.</b> |  |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)<br><b>Hurlock</b>   |  | c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)<br><b>Hurlock R.F.D. (Bobtown)</b>                          |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>R.F.D.</b>   |  | e. STREET ADDRESS<br><b>1</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Clarence</b>   |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>18</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>M</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>5/26/03</b>  |  |
| 9. AGE (In years last birthday)<br><b>58 yrs.</b>   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><b>58 yrs.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Edgar Elbert</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Atkinson</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Edgar Elbert, Hurlock, Md.</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>4-4-1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) }<br>stating the underlying cause last. (c) }<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/><br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19<br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DATE SIGNED <b>10/18/61</b><br>Address (Street, city, town, or county)<br>22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b><br>22b. DATE THEREOF<br><b>Oct. 21, 1961</b><br>22c. NAME OF CEMETERY OR CREMATORY<br><b>Thompsonstown Cemetery</b><br>22d. LOCATION (City, town, or country) (State)<br><b>Near East New Market, Maryland</b><br>23. FUNERAL DIRECTOR<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b><br>ADDRESS<br>24a. REC'D BY REGISTRAR<br><b>OCT 24 '61</b><br>24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b> |  |   |  |

VS. A15M8  
5M 7/59



(M)

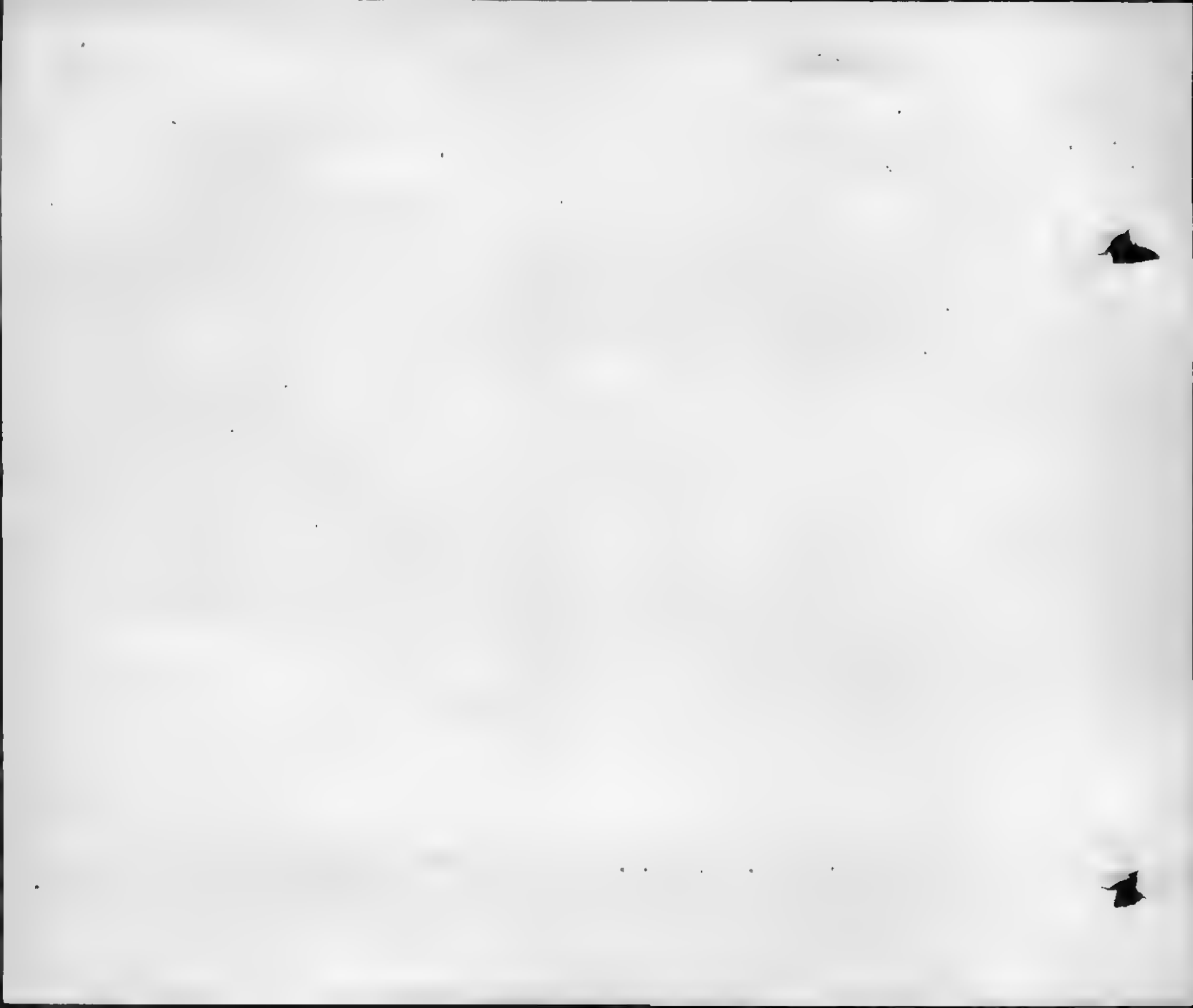
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11340

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11325

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>CAMBRIDGE (RD 2) MD.</b>				c. LENGTH OF STAY IN 1b <b>3 MONTHS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS <b>SOUTH SOMERSET AVE.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>TYLER</b> Last <b>EVANS</b>				4. DATE OF DEATH Month <b>OCT</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-6-80</b>	
9. AGE (In years lost birthday) <b>81</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>SOLOMON EVANS</b>				14. MOTHER'S MAIDEN NAME <b>ANNA E. BRADSHAW</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-03-1445</b>		17. INFORMANT Address <b>EASTERN SHORE STATE HOSPITAL RECORDS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>MYOCARDIAL DEGENERATION</b> DUE TO (c) <b>ATHEROSCLEROTIC C.V.D.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HR.</b> <b>2 YEARS</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (he) (this hospital) attended the deceased from <b>JULY 7, 1961</b> to <b>OCT. 10, 1961</b> , that (he) (we) last saw the deceased alive on <b>OCT. 10, 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Geo M. Dunn</b> M.D.				22b. DATE SIGNED <b>10-10-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>George M. DUNN, M.D.</b>				22d. ADDRESS <b>Eastern Shore State Hospital, Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>OCT. 12, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNNYRIDGE CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>CRISFIELD, MARYLAND Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Bradshaw</b> ADDRESS <b>CRISFIELD, MD.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Thomas</b>	





FOR STATE  
HEALTH DEPT.

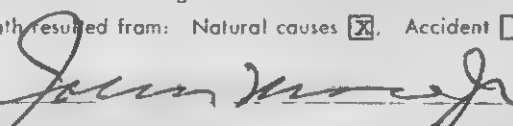

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11326

11341

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Dorchester</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c LENGTH OF STAY IN lb <b>Life</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		d STREET ADDRESS <b>59 Douglass St.</b>	
3. NAME OF DECEASED (Type or print) <b>Maggie Hayward Fields</b>		4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 26, 1898</b>
9. AGE (In years last birthday) <b>68 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beckwith, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel W. Hayward</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia Henson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-7947</b>	
17. INFORMANT <b>Edmond Haywadr</b>		Address <b>59 Douglass Cambridge</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Colitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Massive hemorrhage</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>10/31/61</b>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/19/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert M. St.Clair</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 6 '61</b>		24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If or delay is necessary, please  
to the funeral director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

File #291-11/1/61-227.

Two per on sent for the - it is reported as  
leg death a it signed by L. & L. in front  
underage No.

1  
FOR STATE  
HEALTH DEPT.

# STATE OF MARYLAND

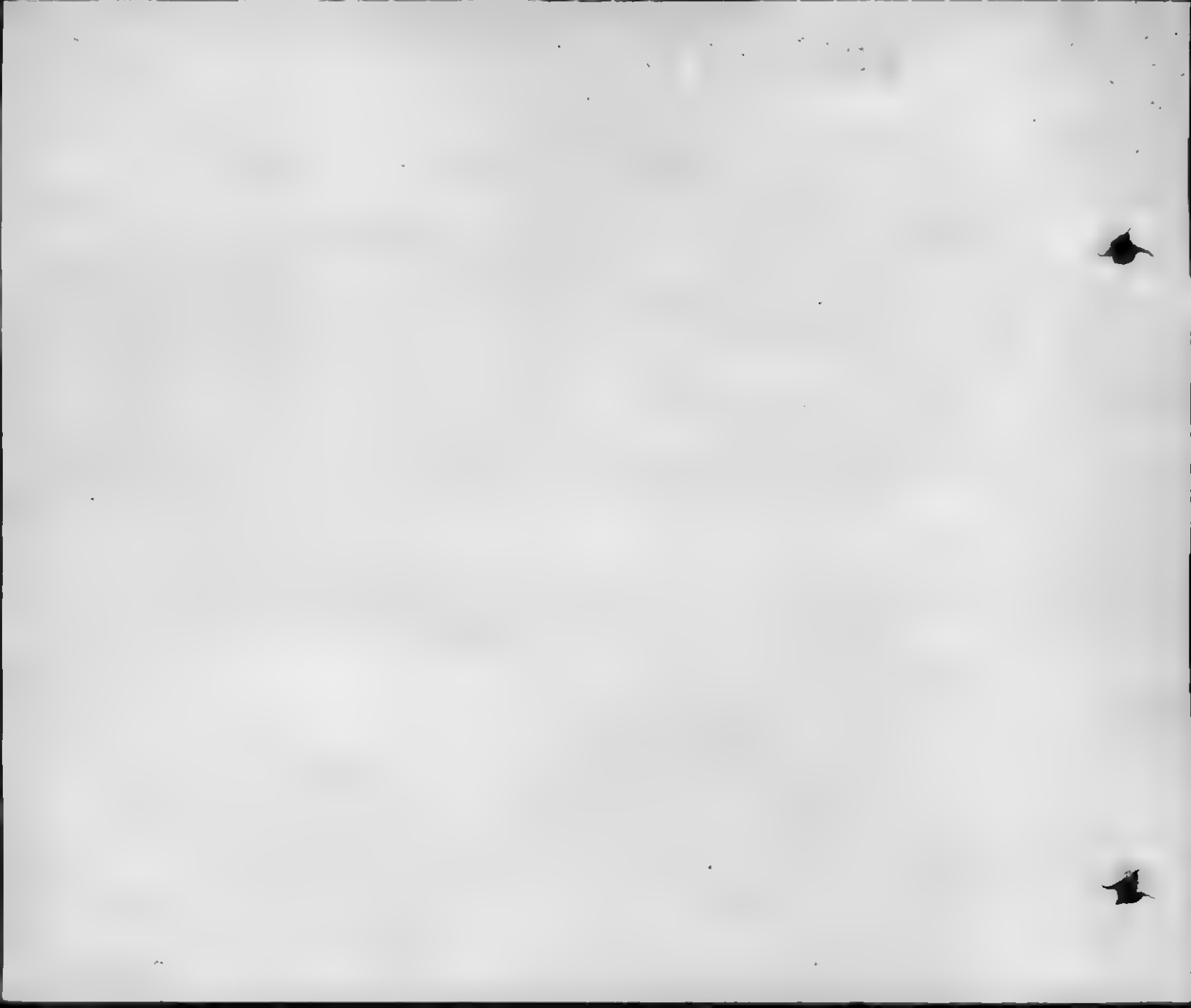
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 11342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11327

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural--- Aireys Life</b> c. LENGTH OF STAY IN TB <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural--- Aireys</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Johnann</b> First Middle Last 4. DATE OF DEATH <b>October 17 1961</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Aug. 29, 1889</b> 9. AGE (in years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <b>Dorchester County</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John W. Stanley</b> 14. MOTHER'S MAIDEN NAME <b>Millie Kiah</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <b>Raymond Fisher Rt. #2 Dorchester Co.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>Abt. 4 da.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>10/23/61</b> Address (Street, city, town, or county) ACTUAL SIGNATURE <b>John Mace Jr. M.D.</b> EXAMINER'S NAME (Type) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>10/22/61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Aireys</b> ADDRESS 22d. LOCATION (City, town, or country) (State) <b>Aireys, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 26 '61</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Herbert M. St. Clair</b>	
23. FUNERAL DIRECTOR <b>Herbert M. St. Clair Cambridge, Md.</b>			

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it may be executed at any time within 72 hours after death. Pages 1, 2, and 3 to be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



11343

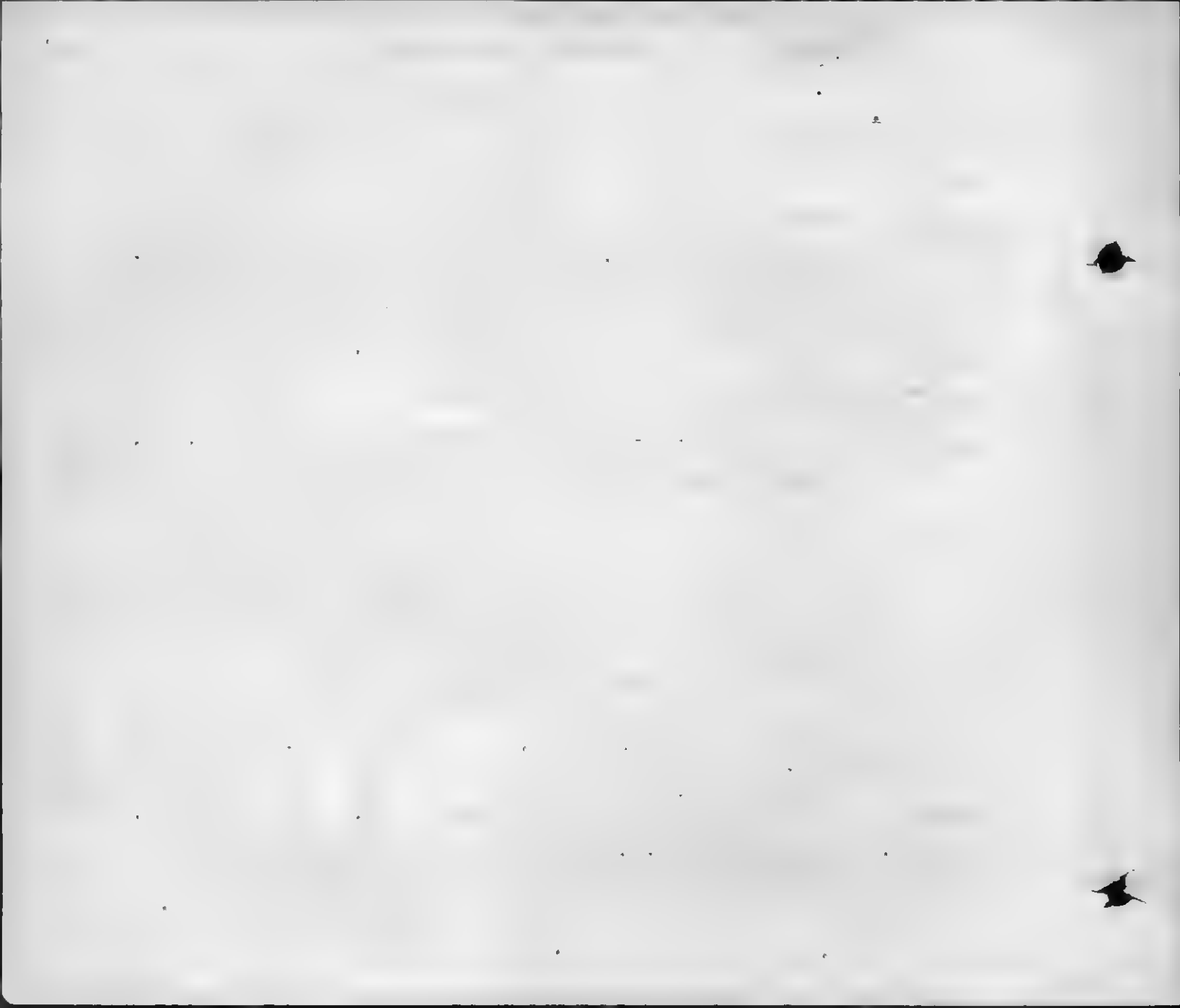
CERTIFICATE OF DEATH

Reg. Dist. No. 11328

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Creek</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Creek</b>			
c. LENGTH OF STAY IN 1b <b>life</b>				d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emmons</b> Middle <b>N.</b> Last <b>Foster</b>				4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 12, 1900</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dor-Co-Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Alfred Foster</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Kiah</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>unk</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>220-03-9769</b>				17. INFORMANT <b>Hazel Foster-Church Creek, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pemphigus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <b>19</b> Hour <b>a. m.</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 17, 1961</b> to <b>October 9, 1961</b> , that I last saw the deceased alive on <b>October 9, 1961</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. 227 Pine St., Cambridge, Md.</b> DATE SIGNED <b>10/10/61</b>							
ACTUAL SIGNATURE <b>J. Edwin Fassett, M.D.</b>				PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/13/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Christ Rock, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert M. St. Clair</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 26 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Kiana</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11329

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write R.U.P.A. and give nearest town) <b>rural Cambridge, Md</b> c. LENGTH OF STAY IN 1b <b>2 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>72 CHESTNUT WAY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Theodosia Benton Greene</b>		4. DATE OF DEATH <b>October 11 1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/8/1881</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ashley Benton</b>		14. MOTHER'S MAIDEN NAME <b>Sallie CROWDER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Medical Records, Eastern Shore State Hosp., Cambridge</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>782.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 Mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture Fe mur</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Slipped and fell getting out of bed.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:10 a.m. 11-24-60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>E.S.S. Hosp.</b>		20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		DATE SIGNED <b>10/11/61</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVED</b>		22b. DATE THEREOF <b>10-12-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mardela Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson</b>		24a. REC'D BY REGISTRAR <b>Oct 13 1961</b>	
ADDRESS <b>Salisbury, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Mace</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



P. S. A.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11345

11330

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b> c. LENGTH OF STAY IN IS <b>38 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>106 PEACHBLOSSOM AVE.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b> d. STREET ADDRESS <b>106 PEACHBLOSSOM AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ALVINA PETERS HINTZ</b> <b>5. SEX</b> <b>F</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>APRIL 8, 1874</b> <b>9. AGE</b> (In years last birthday) <b>87 yrs.</b> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <b>OCTOBER 2 1961</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>APPLETON, WISCONSIN</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>ALBERT PETERS</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b> <b>16. SOCIAL SECURITY NO</b> <b>NONE</b> <b>17. INFORMANT</b> <b>GLADYS HINTZ</b> Address <b>CAMBRIDGE, MD.</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>FREDRIKA PETERS</b> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atypical Pneumonia</b> (b) <b>4 days</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>9/29/61</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>10/12/61</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>10/4/61</b> <b>1961</b> <b>to</b> <b>10/12/61</b> <b>1961</b> <b>that (I) (we) saw the deceased alive on</b> <b>10/4/61</b> <b>1961</b> <b>and that death occurred at</b> <b>11 A.M.</b> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>JOHN MACE JR.</b> <b>22b. DATE SIGNED</b> <b>10/13/61</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>JOHN MACE JR.</b> <b>22d. ADDRESS</b> <b>CAMBRIDGE MD.</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>23b. DATE THEREOF</b> <b>10-4-61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>EAST NEW MARKET</b> <b>23d. LOCATION (City, town or county)</b> <b>EAST NEW MARKET MD.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Kenneth R. Thomas</b> <b>ADDRESS</b> <b>CAMBRIDGE MD.</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Kraus</b> <b>DATE</b> <b>OCT 5 '61</b>			

MEDICAL CERTIFICATION

The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death.

200

## CERTIFICATE OF DEATH

11331

Reg. Dist. No.

11346

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY N.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md, Glenburn Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smyrna Delaware	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home		d. STREET ADDRESS 40 X-3	
3. NAME OF DECEASED (Type or print) First Middle Last Lonah H. Hodgson		4. DATE OF DEATH 10/21/61 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1873 yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		11. BIRTHPLACE (State or foreign country) Md.	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry M. Smith		14. MOTHER'S MAIDEN NAME Mary Wiley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT M.S. Hodgson, Bunker Hill Farm, Trappe Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7-2048 DUE TO 11/1/1961 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY a. H. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/21/61 to 10/21/61, that I last saw the deceased alive on 10/21/61, and that death occurred at 10/21/61, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/24/61	22c. NAME OF CEMETERY OR CREMATORY Townsend Cemetery	22d. LOCATION (City, town, or county) (State) Townsend Delaware
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Smith, Middletown, Del.		24a. REC'D BY REGISTRAR DATE OCT 26 '61	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

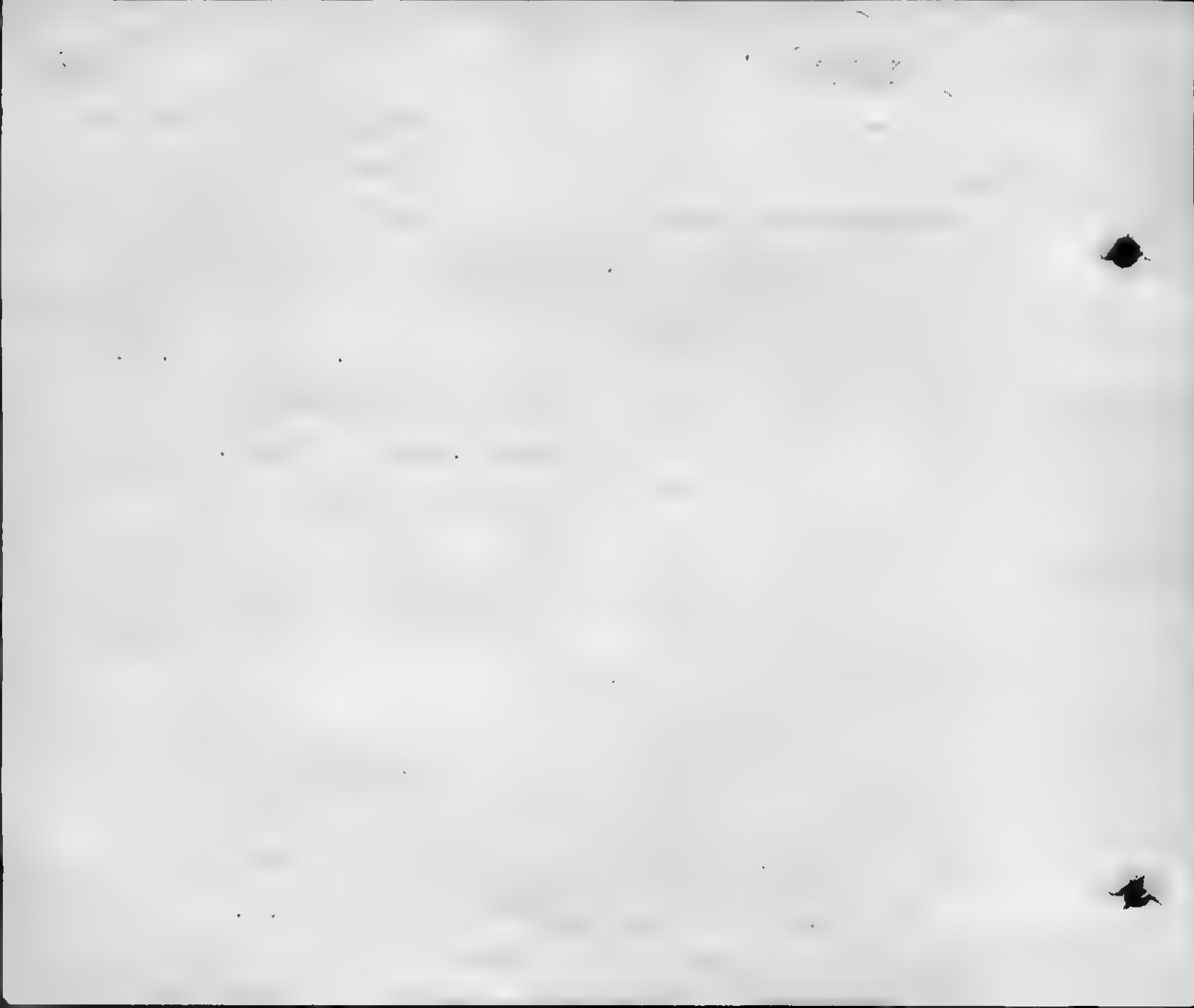
VR A15 (4)  
ISM 9/60

1  
(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11347											
11332											
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN Ill <b>Lifetime</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>				d. STREET ADDRESS <b>313 Race St.</b>							
3. NAME OF DECEASED (Type or print) <b>Elizabeth M. Jones</b>				4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1961</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 25, 1906</b>		9. AGE (in years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Public School Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herbert McMahon</b>				14. MOTHER'S MAIDEN NAME <b>Mannah Saunders</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Kenneth R. Jones</b>				Address <b>Cambridge Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary sclerosis</b> (a), stating the underlying cause last. DUE TO (c) <b>?</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days+</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9-30-61</b> to <b>10-3-1961</b> , that (I) (we) last saw the deceased alive on <b>10-3-1961</b> , and that death occurred at <b>10:30 am</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Eldridge H. Wolff</b>				22b. DATE SIGNED <b>10-4-61</b>				22c. PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>			
22d. ADDRESS <b>15 Locust St., Cambridge, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Oct. 6, 1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>			
23d. LOCATION (City, town or county) <b>Boston, Md.</b>				23e. (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas Jr.</b>				25a. REC'D BY REGISTRAR <b>Arthur S. Thomas</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			
DATE <b>OCT 10 '61</b>											



11348

## CERTIFICATE OF DEATH

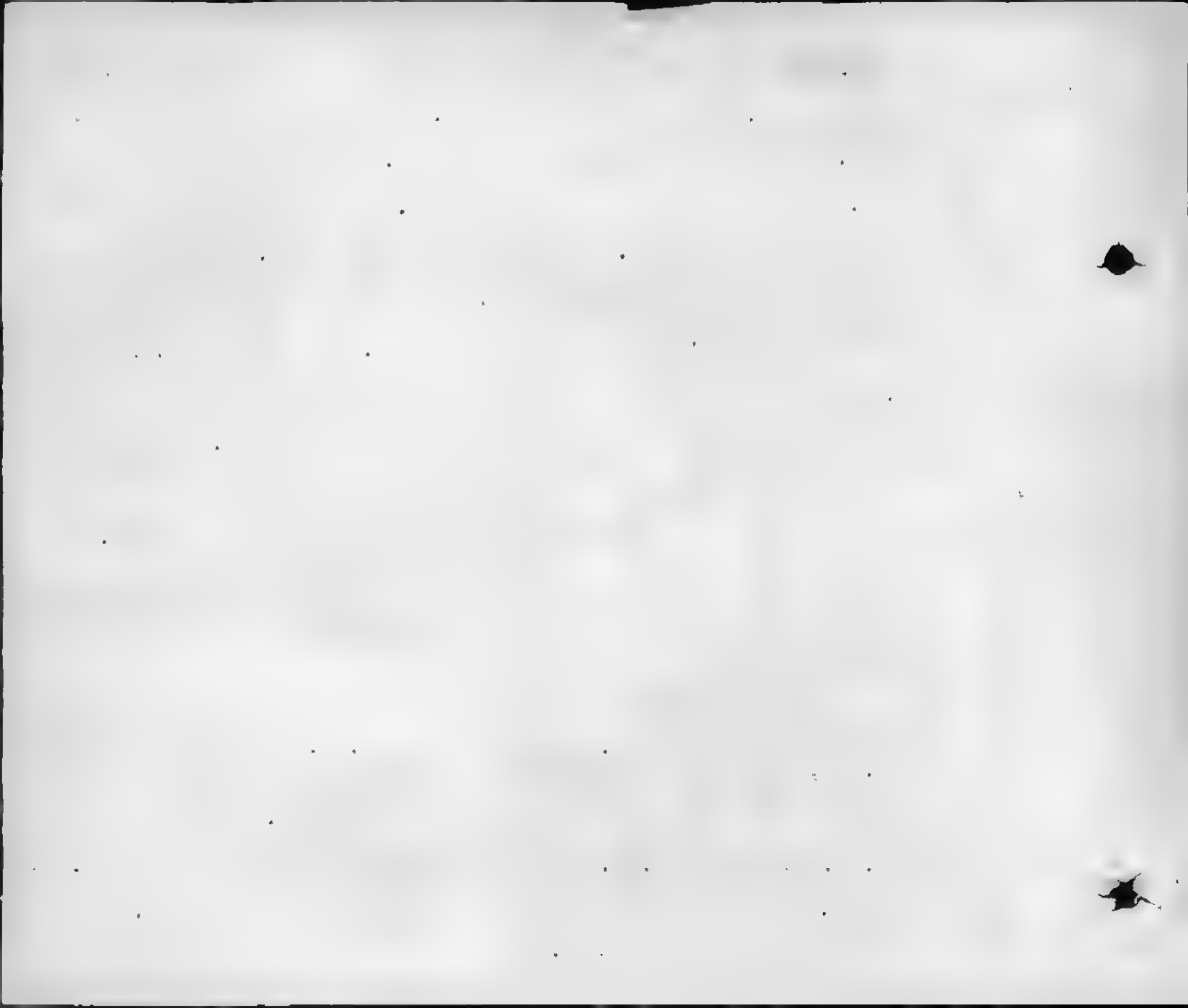
Reg. Dist. No.

11333

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wingate, Md.</b>	
c. LENGTH OF STAY IN 1b <b>18 Days</b>		d. STREET ADDRESS <b>Wingate, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Md. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Winnie</b> Middle <b>H.</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>27</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1888</b>
9. AGE (In years last birthday) yrs. <b>73</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>3</b> Hours <b>15</b> Min.	IF UNDER 24 HRS Months <b>7</b> Days <b>3</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>Wingate, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob T. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Eldred Jones</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of prostate with metastasis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Oct. 9, 61</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 9, 1961</b> , to <b>Oct. 27, 19 61</b> that I last saw the deceased alive on <b>Oct. 27, 1961</b> and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>104 Locust St., Cambridge, Maryland</b> DATE SIGNED <b>Nov 7 '61</b>			
ACTUAL SIGNATURE <b>W. H. Henke</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. W. H. Henke, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 29, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Wingate, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

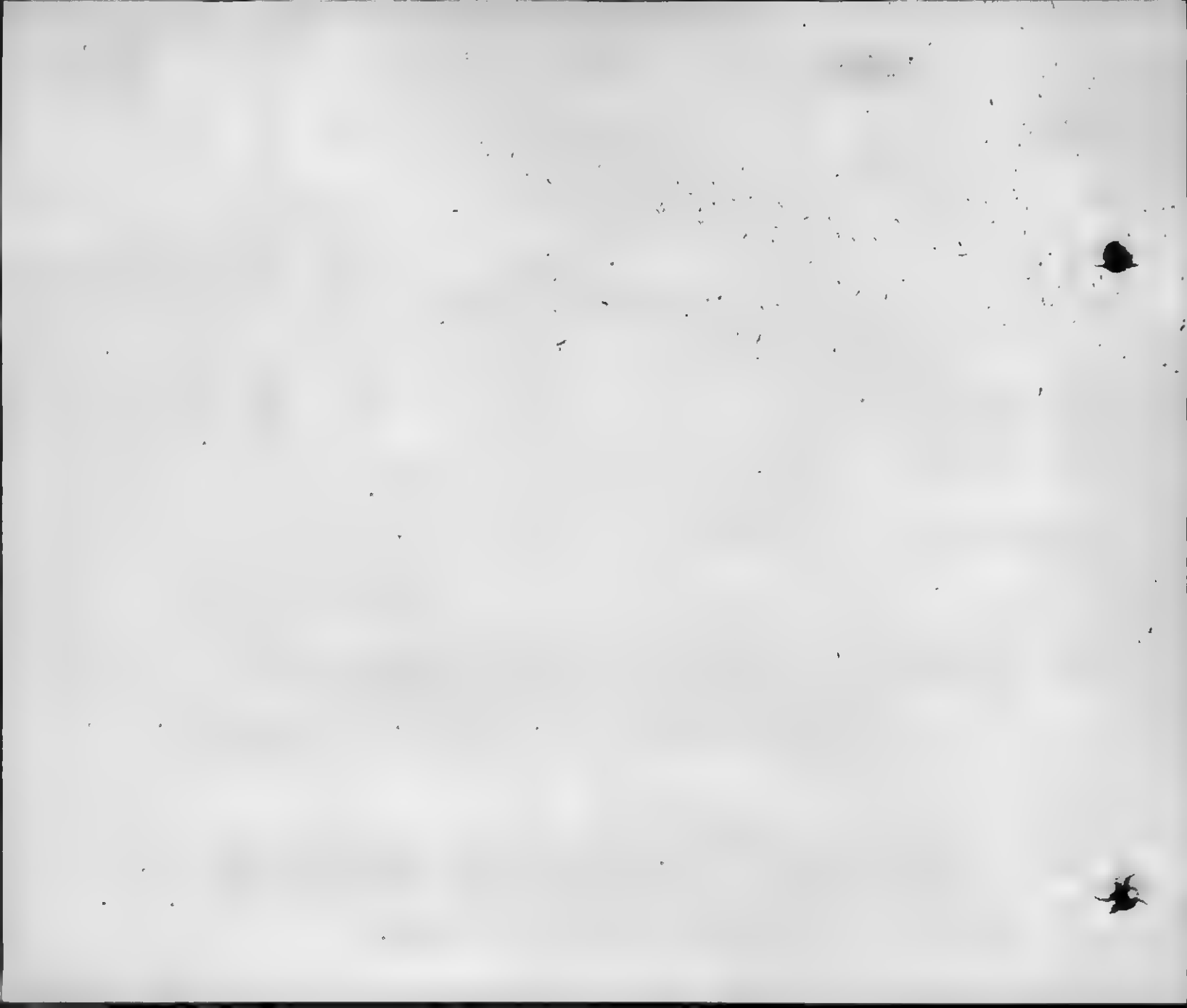


# 1 FOR STATE HEALTH DEPT.

any delay is necessary, this certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u> d. STREET ADDRESS <u>Broad</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>15 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>James W. Kelly</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>14</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/5/1906</u>	
<b>9. AGE</b> (In years last birthday) <u>55</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>55</u> Days <u>55</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>55</u> Min. <u>55</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Night watchman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Canning plant</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>13. FATHER'S NAME</b> <u>William J. Kelly</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Georgia Howeth</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Orem Kelly</u> <u>Seaford, Del.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tension pneumothorax, left.</u> DUE TO (b) <u>Crushing wound of chest.</u> DUE TO (c) <u>Crushing wound of chest.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)							
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>15 Hrs.</u> <u>15 Hrs.</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <u>Driver of a car which failed to make curve, struck a tree.</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>10/13/61</u> Hour <u>4</u> min. <u>p.m.</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Rt. 14</u>		<b>20f. (City or town) (County)</b> <u>Nr. Rhodesdale, Dor., Md.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from</b> <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input checked="" type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>John Mace Jr.</u>				<b>DATE SIGNED</b> <u>10/16/61</u>			
<b>EXAMINER'S NAME</b> (Type) <u>John Mace Jr. M.D.</u>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>Cambridge, Md.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>10/17/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>McKendree Cemetery</u>		<b>22d. LOCATION</b> (City, town, or country) (State) <u>Rhodesdale, Dor., Md.</u>	
<b>23. FUNERAL DIRECTOR</b> <u>Willoughby Funeral Home East New Market, Md.</u>				<b>24a. RECD BY REGISTRAR</b> <u>OCT 19 61</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

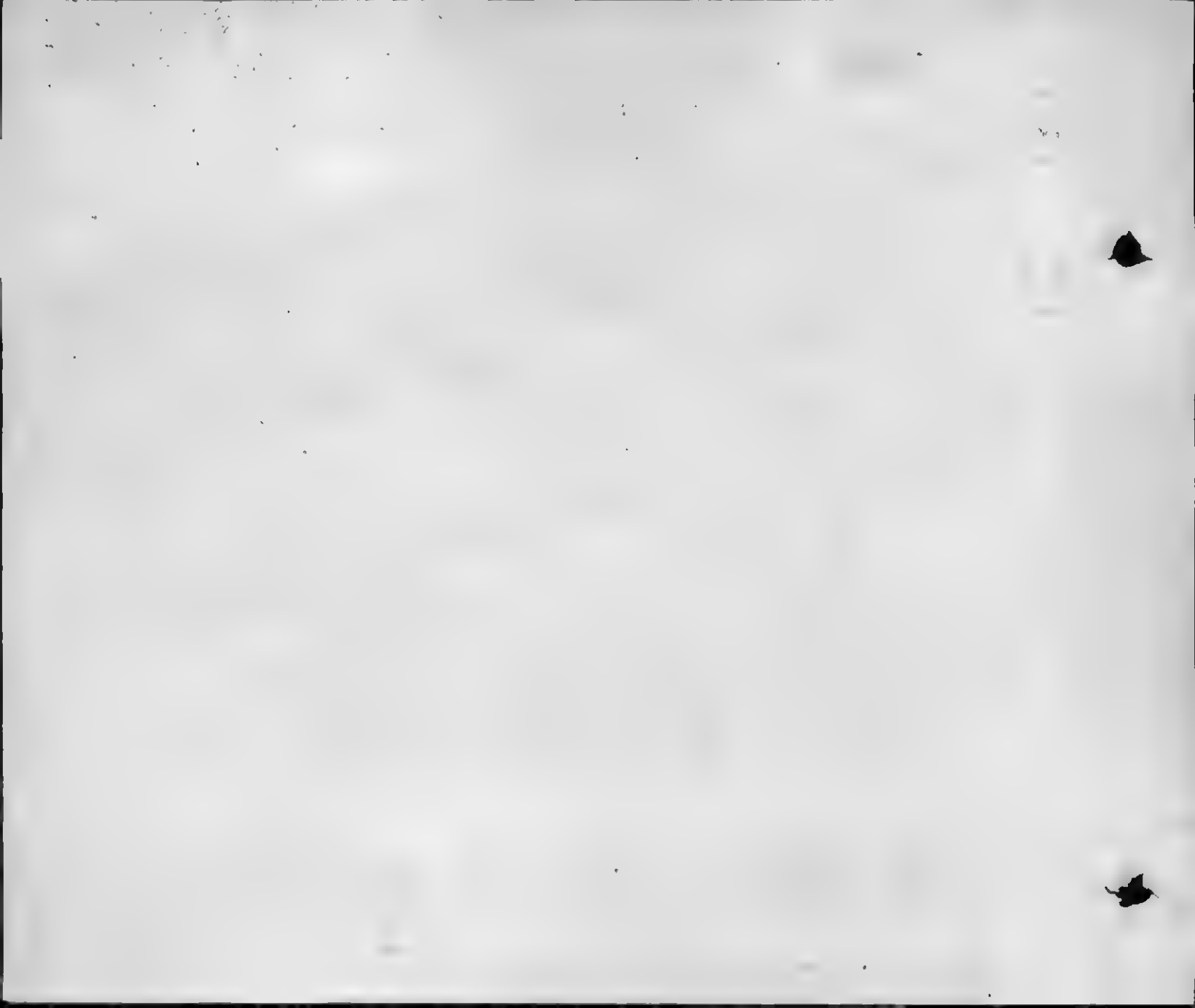
**11350**

**11335**

**FOR STATE HEALTH DEPT**

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY in lb <u>8 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20 Cross St.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution's Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>20 Cross St.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Roosevelt</u> <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> <u>October 8 1961</u> <b>9. AGE</b> (In years, IF UNDER 1 YEAR IF UNDER 24 HRS.) <u>40</u> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Florida or Georgia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>Unknown</u> <b>16. SOCIAL SECURITY NO.</b> <u>252-40-0162</u> <b>17. INFORMANT</b> <u>City Police Dept. Cambridge</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute alcoholism</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> and in my opinion death resulted from _____ Natural causes <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>John Mace Jr.</u> <b>EXAMINER'S NAME (Type)</b> <u>John Mace Jr. M.D.</u>		<b>DATE SIGNED</b> <u>11/2/61</u> <b>Address (Street, city, town, or county)</b> <u>Cambridge, Md.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>10/23/61</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Waugh</u> <b>22d. LOCATION (City, town, or country)</b> <u>Cambridge Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>NOV 6 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Knud</u>	
<b>23. FUNERAL DIRECTOR</b> <u>Herbert M. St. Clair</u> <u>Cambridge, Md.</u>			





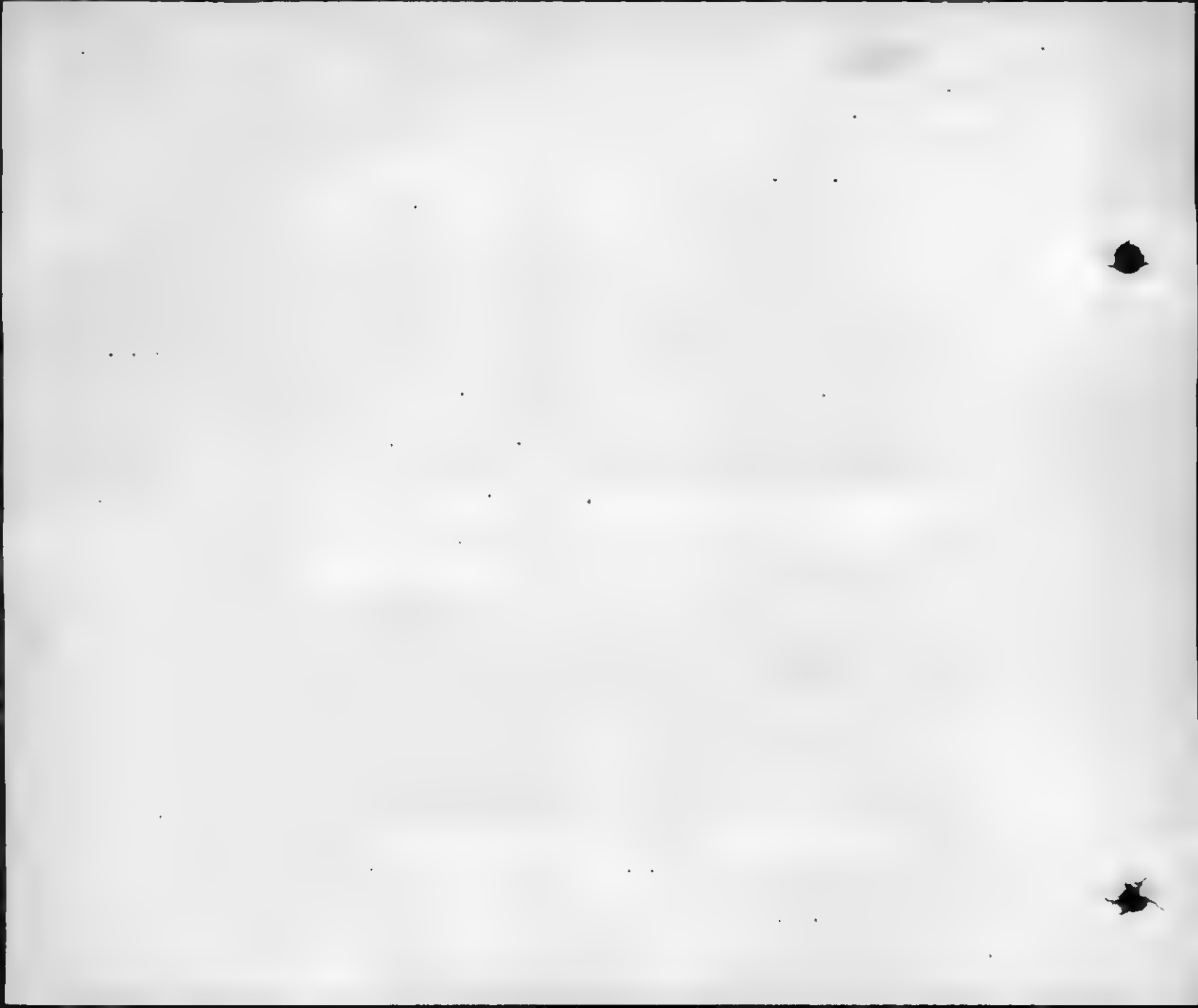
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**11351**

**11336**

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN lb <b>8½ years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) First <b>Elizabeth</b> Middle <b>Ann</b> Last <b>Medford</b>		<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>2</b> Year <b>1961</b>	
<b>5 SEX</b> <b>Female</b>	<b>6 COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>August 18, 1883</b>
<b>9 AGE</b> (In years last birthday) <b>78 yrs</b>		<b>IF UNDER 1 YEAR</b> Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	<b>IF UNDER 24 HRS</b> Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Loudon County, Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Joseph B. Woodward</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Ann Woodward</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO</b> <b>None</b>	
<b>17 INFORMANT</b> <b>Mrs. Herbert S. Slacum, Cambridge, Maryland</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Broncho pneumonia</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Massive cerebral hemorrhage with left hemiplegia</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>30 hr.</b> <b>16 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			<b>19 WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) -----	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21 I certify that (I) (this hospital) attended the deceased from 9-16-61 to 10-2-1961, that (I) (we) last saw the deceased alive on 10-2-61 19, and that death occurred on 10-2-61 19, from the causes and on the date stated above.</b>			
<b>22a SIGNATURE</b> <i>Eldridge H. Wolff</i>		<b>22b DATE SIGNED</b> <b>10-4-61</b>	
<b>22c PHYSICIAN'S NAME (Type)</b> <b>Eldridge H. Wolff, M.D.</b>		<b>22d ADDRESS</b> <b>15 Locust St., Cambridge, Maryland</b>	
<b>23a BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>Oct. 5, 1961</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Washington Cemetery</b>	<b>23d LOCATION (City, town, or county) (State)</b> <b>Hurlock, Maryland</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J.J. Framptom and Son, Federalsburg, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE OCT 10 '61</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles L. House</i>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11352

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11357

FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

016

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
c. LENGTH OF STAY IN 1b <b>1 yr &amp; 10 mos</b>		d. STREET ADDRESS <b>1439-J</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>			
3. NAME OF DECEASED (Type or print) <b>Ernest</b> First Middle Last		4. DATE OF DEATH <b>October 17, 1961</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/75</b> 9. AGE (In years last birthday) <b>86</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mr. / Master John Mister</b>		14. MOTHER'S MAIDEN NAME <b>Mary Pruitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO <b>218-40-5081</b>	
17. INFORMANT <b>Hospita l Records E.S.S.H. Cambridge, Md</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> (b) <b>420</b> DUE TO (c) <b>instant</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of femur, right</b> (b) <b>420</b> DUE TO (c) <b>instant</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>slipped and fell on the ground</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:45 a.m. June 26 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Cambridge</b> (County) <b>Dorchester</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace, Jr.</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>October 17, 1961</b>	
EXAMINER'S NAME (Type) <b>John Mace, Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
22b. DATE THEREOF <b>Oct. 19 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Marion</b> (State) <b>MD</b>		24b. REC'D BY REGISTRAR <b>DATE OCT 23 '61</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons H.H. Bradshaw</b> ADDRESS <b>Crisfield</b>		24c. REGISTRAR'S SIGNATURE <b>C. L. - L. K.</b>	



11353

## CERTIFICATE OF DEATH

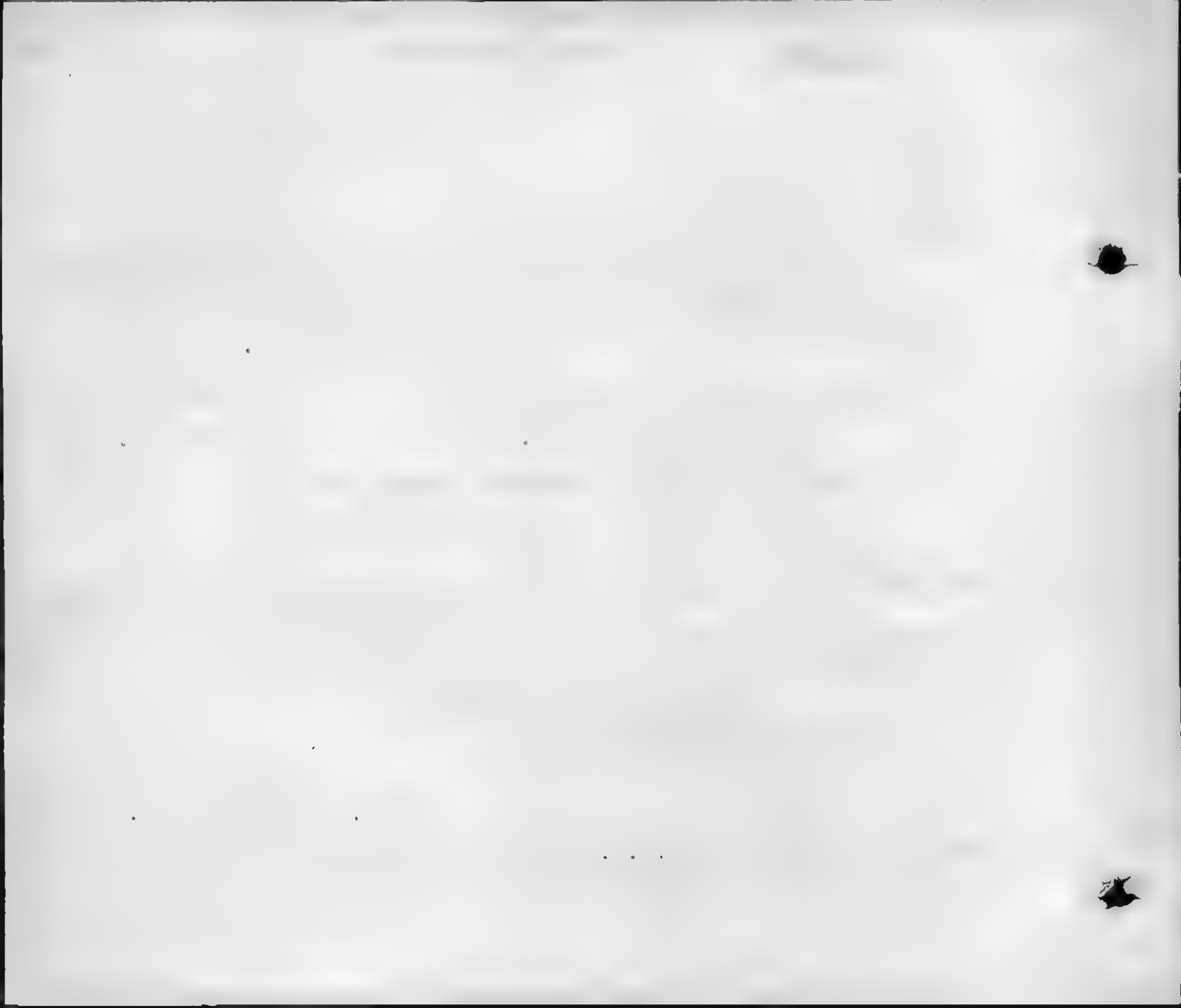
Reg. Dist. No.

11358

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East New Market</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>		e. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Roland</b> Middle <b>Westly</b> Last <b>Neal</b>		4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 34, 1899</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dorchester Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isiah Neal</b>		14. MOTHER'S MAIDEN NAME <b>Millie E. Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>-----</b>	
17. INFORMANT <b>Rev. Edward Hughes</b>		Address <b>Oxford, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 26, 1961</b> , to <b>Oct 29, 1961</b> that I last saw the deceased alive on <b>October 29, 1961</b> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>227 Pine St., Cambridge, Md. 10-29-61</b>			
ACTUAL SIGNATURE <b>J. Edwin Fassett, M.D.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/31/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>	22d. LOCATION (City, town, or county) (State) <b>East New Market, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 6 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

11354

11359

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN b. <u>four weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Memorial Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Duplock</u> d. STREET ADDRESS <u>Charles</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Blanche Mc-Bride Phillips</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>17</u> Year <u>1961</u> <b>8. DATE OF BIRTH</b> Month <u>9</u> Day <u>17</u> Year <u>1897</u> 9. AGE (in years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Thomas E. Mc-Bride</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Brewster</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>493X</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Left Pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>493X</u> (c) <u>Due to</u> (e), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>Nutritional Anemia Severe</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1017 101</u>	
20f. (City or town) <u>Cambridge</u>		20g. (County) <u>Dor</u>		20h. (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/17/61</u> to <u>10/17/61</u> , that (I) (we) last saw the deceased alive on <u>10/17/61</u> , and that death occurred <u>from</u> the causes and on the date stated above.					
22a. SIGNATURE <u>W. H. HARKS</u>		22b. DATE SIGNED <u>10/18/61</u>		22c. PHYSICIAN'S NAME (Type) <u>W. H. HARKS</u>	
22d. ADDRESS <u>CAR BRIDGE MARYLAND</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>10/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dor. Memorial</u>		23d. LOCATION (City, town or county) <u>Cambridge</u>	
23e. REC'D BY REGISTRAR <u>Arthur S. Harkness</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Harkness</u>		23g. DATE <u>OCT 24 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

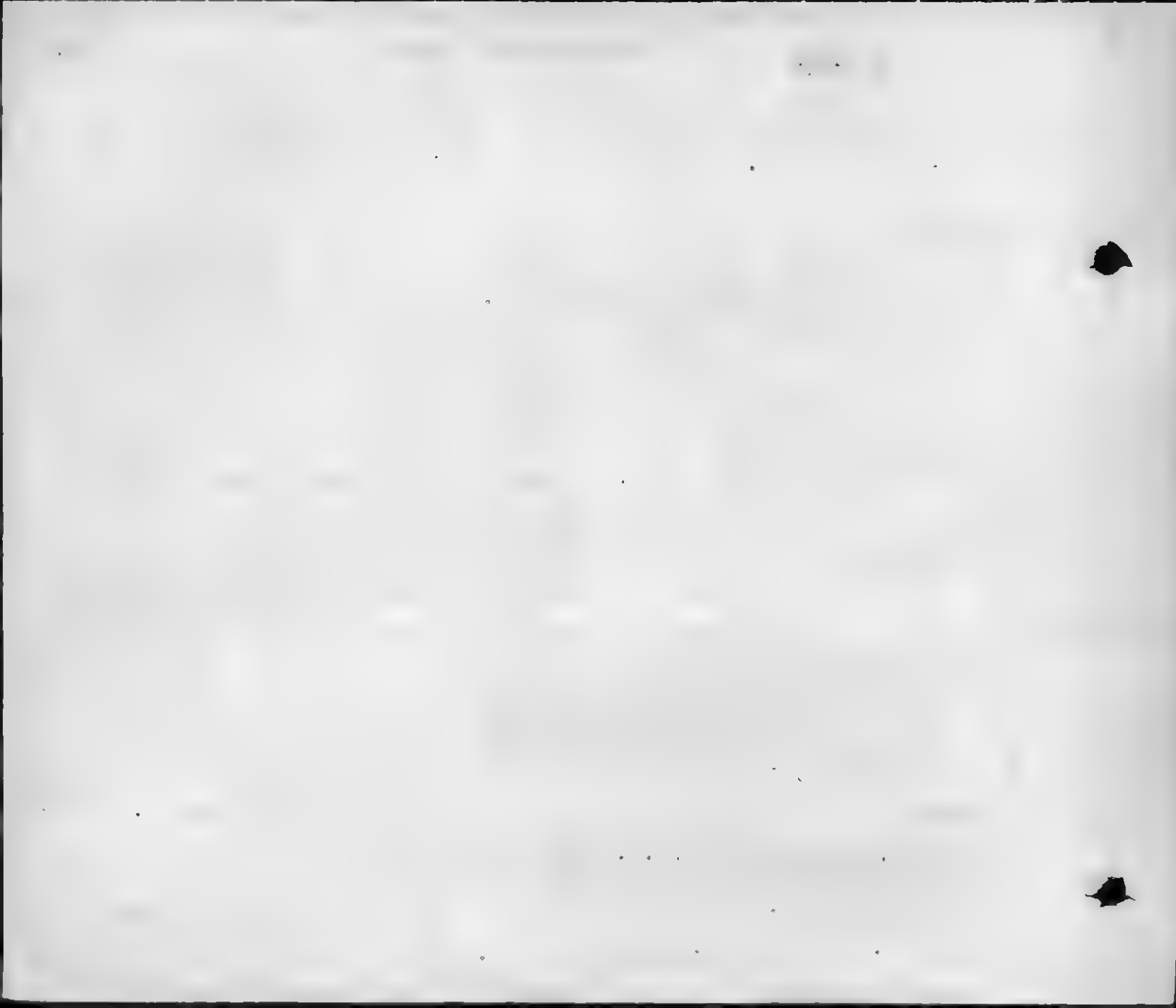
11355

## CERTIFICATE OF DEATH

Reg. Dist. No.

11340

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--- Aireys, Md.</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Pinder</b> Last				4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1864</b>		9. AGE (In years last birthday) yrs. <b>97</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester, County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Agnes Thomas</b>		Address <b>Aireys, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Heart Disease</b>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Cardiac Decompensation</b>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>September 16, 1960</b> to <b>October 16, 1961</b> , that I last saw the deceased alive on <b>October 16, 1961</b> , and that death occurred at _____ M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>[Signature]</i>				M.D. <b>227 Pine St., Cambridge, Md. 10-16-61</b>			
PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/20/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fork Neck</b>		22d. LOCATION (City, town, or county) (State) <b>Fork Neck, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert M. St. Clair, Jr.</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 26 '61</b>	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



## CERTIFICATE OF DEATH

Reg. Dist. No.

11341

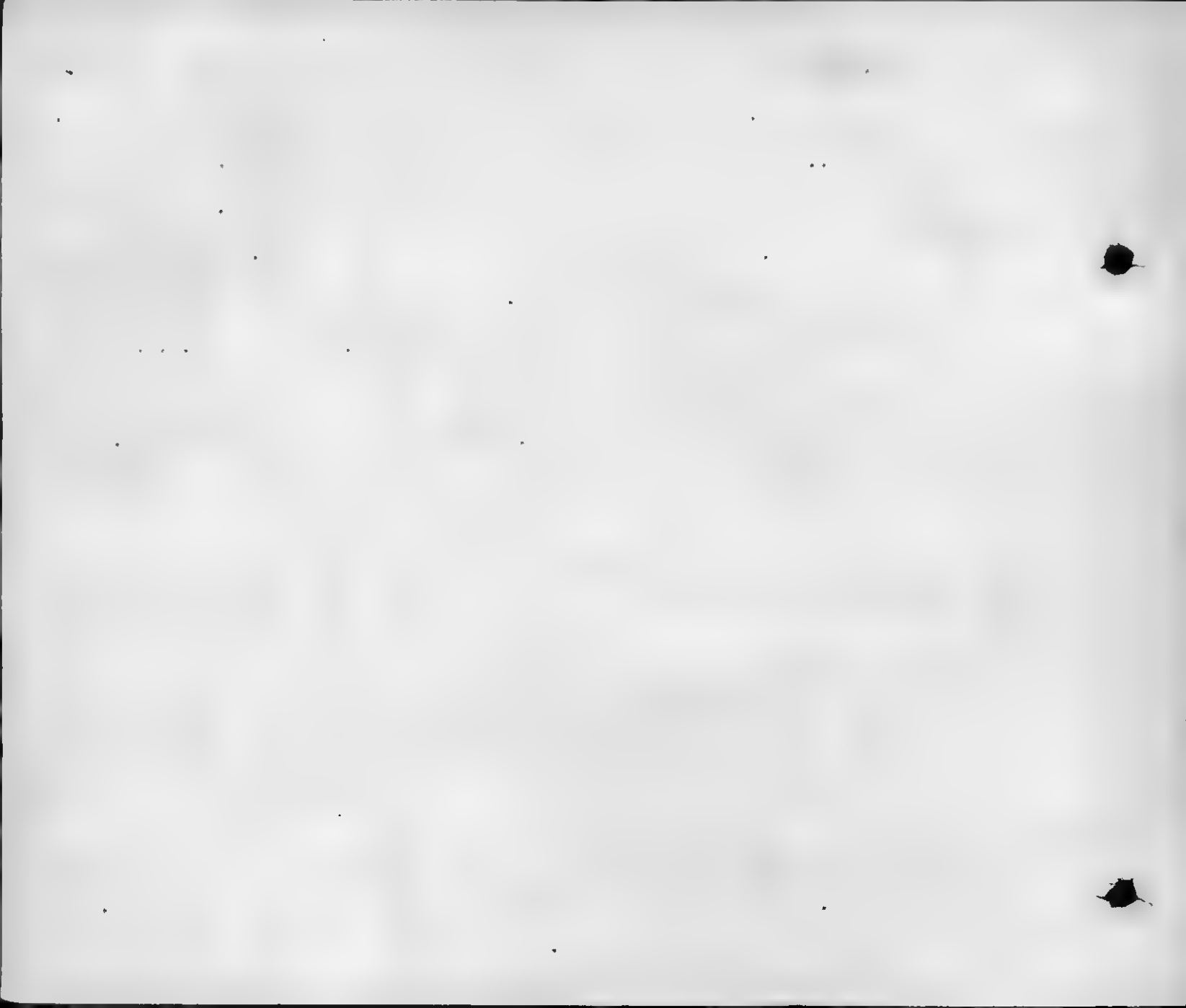
11356

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md..</b>				c. LENGTH OF STAY IN 1b <b>5 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>				e. STREET ADDRESS <b>East New Market, Maryland.</b>			
3. NAME OF DECEASED (Type or print) First <b>J.</b> Middle <b>Ernest</b> Last <b>Redmile</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> Year <b>19 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 12, 1908</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min <b>53</b>		11. BIRTHPLACE (State or foreign country) <b>Lancaster, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cosmetics</b>		11. BIRTHPLACE (State or foreign country) <b>Lancaster, Pa.</b>	
13. FATHER'S NAME <b>Not Known</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Not Known</b>		17. INFORMANT <b>Mrs. Redmile</b>		Address <b>East New Market, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/27</b> , 1961, to <b>10/31</b> , 1961, that I last saw the deceased alive on <b>10/31</b> , 1961, and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>104 LOCUST ST. CAMBRIDGE MARYLAND</b> DATE SIGNED <b>10/31/61</b>							
ACTUAL SIGNATURE <b>W. H. Hanks, M.D.</b>				PHYSICIAN'S NAME (Type) <b>W. H. Hanks, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 2, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Northwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Penn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Hanks</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

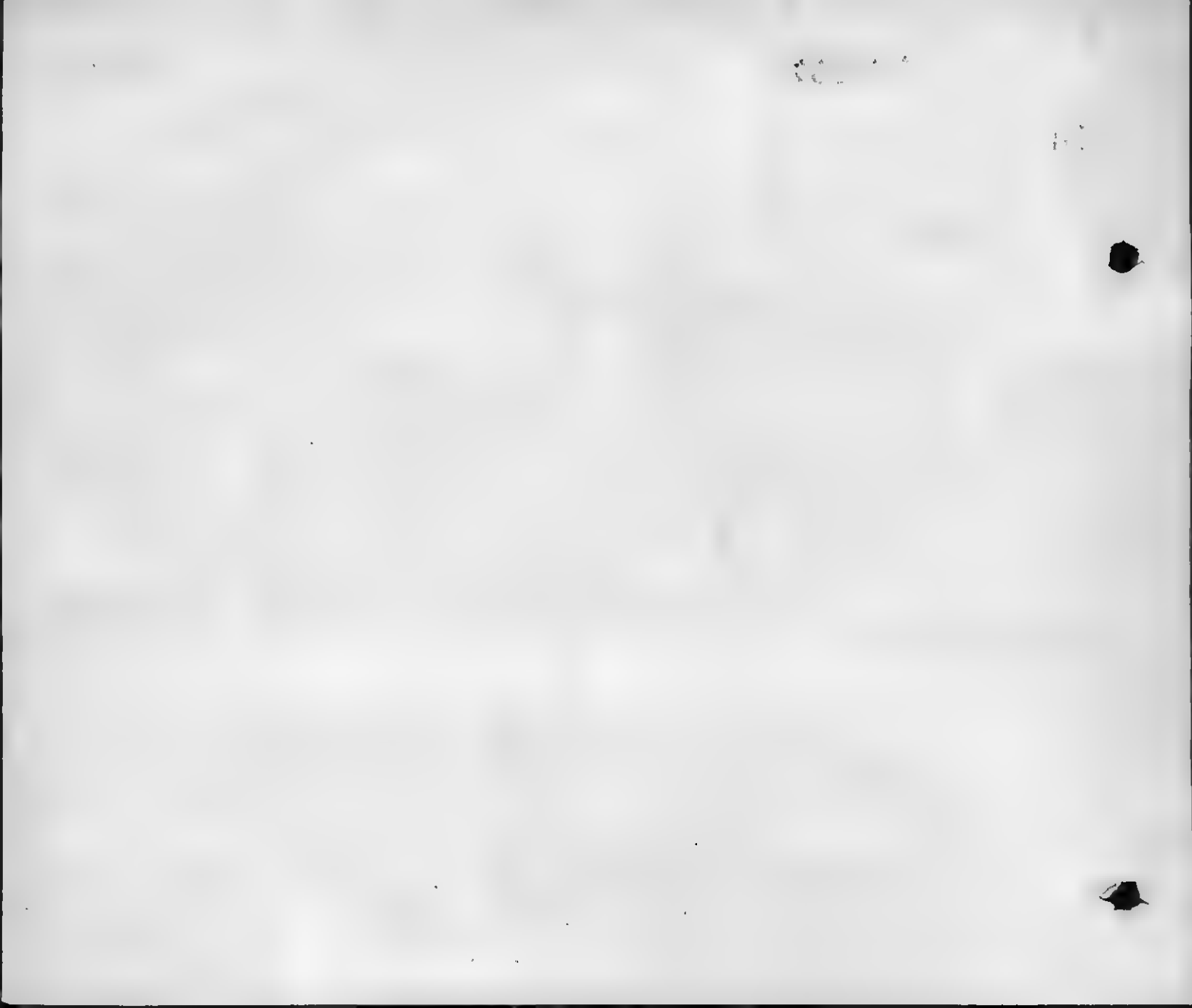
## CERTIFICATE OF DEATH

11357

11342

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>		c. LENGTH OF STAY IN IL <u>1 YR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RISING SUN</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSP.</u>				d. STREET ADDRESS <u>NONE</u>			
3. NAME OF DECEASED (Type or print) First <u>VIOLET</u> Middle <u>LUCY</u> Last <u>RIALE</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/22/06</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CECIL COUNTY, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-14-0821</u>		17. INFORMANT <u>THOMAS RIALE, RISING SUN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u>							
4-20-00 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
DUE TO (c) <u>1 YR +</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>ABSCESS RT. BUTTOCK</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 27, 1960</u> , to <u>OCT. 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>OCT. 30, 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>George H. Longley</u>				22b. DATE SIGNED <u>10/31/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>				22d. ADDRESS <u>EASTERN SHORE STATE HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>11-3-61</u>		<u>Brookview Cemetery</u>		<u>Rising Sun, Cecil, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reid</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 1 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Oct 31 1961</u>				25c. REGISTRAR'S SIGNATURE <u>Oct 31 1961</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be explained in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

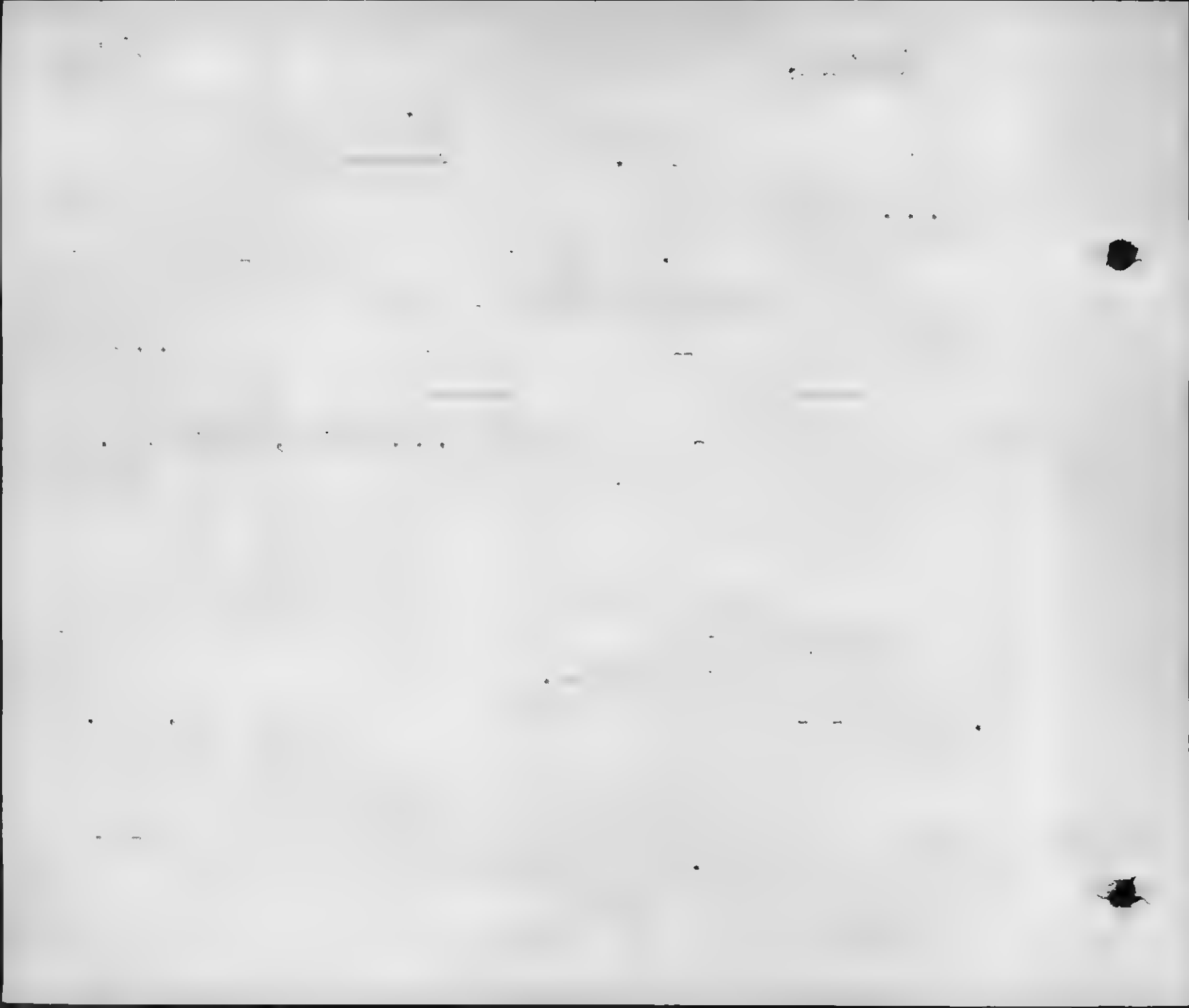
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11343

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>15 Mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>E.S.S. Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greensboro DENTON</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Clara A. Ribbardson</b>		4. DATE OF DEATH <b>10-21 1961</b>		5. SEX <b>F</b>	
6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1871, July 27</b>	
9. AGE (in years last birthday) <b>90</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown PETER HIGNUTT</b>		14. MOTHER'S MAIDEN NAME <b>Unknown MARTHA NEAL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Records E.S.S. Hospital, Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>782.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>-</b> (c) <b>-</b> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture Neck femur</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall out of bed.</b>			
20c. TIME OF INJURY <b>4.20 PM</b>		20d. INJURY OCCURRED <b>While at work</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
20f. (City or town) <b>Cambridge</b>		20g. (County) <b>Dor.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D.		DATE SIGNED <b>10-21-61</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 24, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>	
22d. LOCATION (City, town, or county) <b>Denton</b>		22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR <b>J. Virgil Moore</b>		ADDRESS <b>Denton</b>		24a. REC'D BY REGISTRAR <b>OCT 25 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11359

11341

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b> c. LENGTH OF STAY IN b 1 yr. 8 mo. 28 days d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived - If institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Hill</b> d. STREET ADDRESS <b>17X-1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Edward Robinson</b> First Middle Last 4. DATE OF DEATH <b>Oct 1 1961</b> Month Day Year		5. SEX <b>M</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>1/15-02</b> 9. AGE (in years last birthday) <b>58</b> 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Robinson</b> 14. MOTHER'S MAIDEN NAME <b>Meg Bromley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <b>Hospital records Cambridge Md</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>286.5 Uremia due to malnutrition</b> DUE TO (a) <b>malnutrition</b> DUE TO (b) <b>malnutrition</b> DUE TO (c) <b>malnutrition</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Link</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Jan 4 1960</b> to <b>Oct 1 1961</b> , that (I) (we) last saw the deceased alive on <b>Oct 1 1961</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Thomas J. Dredge</b> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge, M.D.</b> 22d. ADDRESS <b>E.S.S. Hospital, Cambridge, Md.</b> 22b. DATE SIGNED <b>10-1-61</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>Oct. 4</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield</b> 23d. LOCATION (City, town, or county) (State) <b>Centerville Ind.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b> ADDRESS <b>Church Hill Md.</b> 25a. REC'D BY REGISTRAR <b>DATE OCT 5 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

Reg. Dist. No.

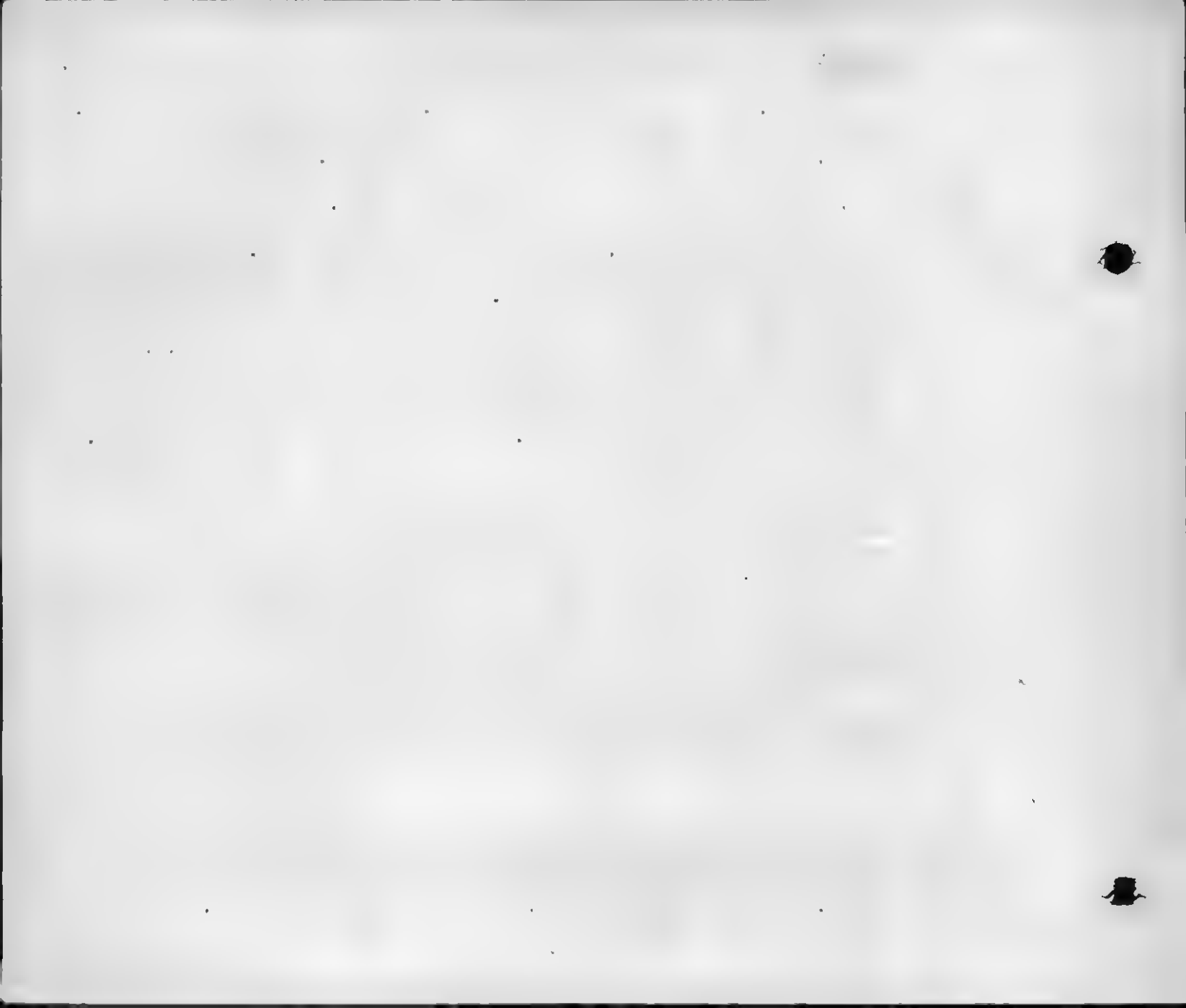
11345

11360

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Md. Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hoopersville, Md.</b>	
f. STREET ADDRESS <b>Hoopersville, Md.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>C.</b> Last <b>Ruark</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>4,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 18, 1874</b>
9. AGE (In years last birthday) yrs. <b>87</b>		10. IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Ruark</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Meekins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. Elizabeth Simmons</b>		Address <b>Hoopersville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC</b> DUE TO <b>SENILITY</b> (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/30, 1961</b> to <b>10/4, 1961</b> , that I last saw the deceased alive on <b>10/4, 1961</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>104 Locust St Cambridge Md</b> DATE SIGNED <b>10/6/61</b>			
ACTUAL SIGNATURE <b>W. H. Hanks</b> M.D.		PHYSICIAN'S NAME (Type) <b>W. H. HANKS</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 8, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 13 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Hanks</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon flaps. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 11346

11361

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>			
c. LENGTH OF STAY IN 1b <b>50 Yrs.</b>				d. STREET ADDRESS <b>211 West End Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Md. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Wilbur</b> Middle <b>N.</b> Last <b>Slacum</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1893</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Taylors Island</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Howard Slacum</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hurley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO		17. INFORMANT <b>Mrs. Wilbur Slacum</b>		Address <b>211 West End Ave.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 20, 1961</b> to <b>Oct 20, 1961</b> , that I last saw the deceased alive on <b>Oct 20, 1961</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Albert E. Bunker</b>		M.D. <b>200 Maryland Ave. Cambridge Md.</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>10/27/61</b>	
PHYSICIAN'S NAME (Type) <b>ALBERT E. BUNKER, M. D.</b>		<b>CAMBRIDGE, MARYLAND</b>					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 23, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Cambridge, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 1 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

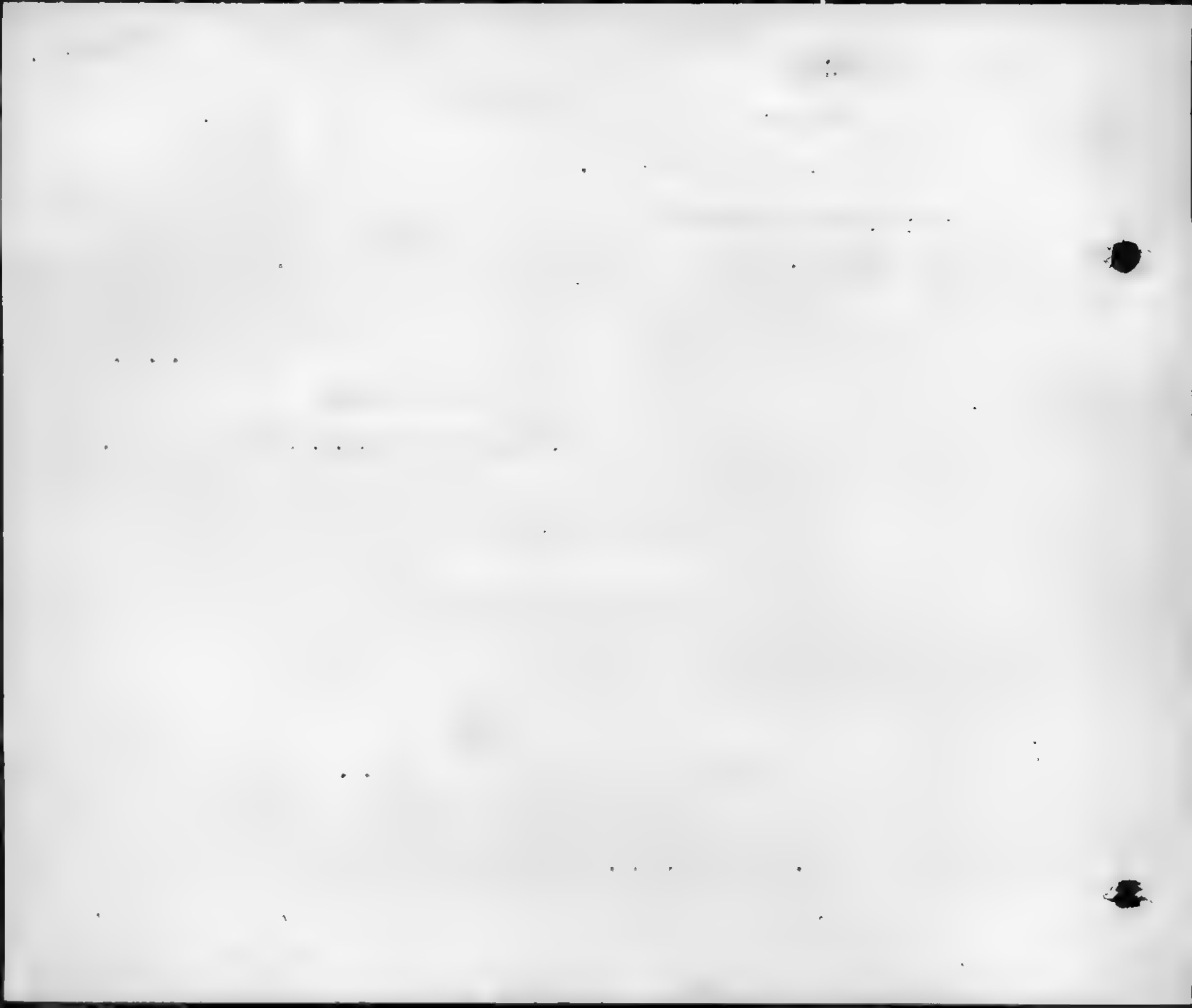


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**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11362

11347

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>2yrs-5mon.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crumpton</b> d. STREET ADDRESS <b>none</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles M. Snitcher</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>Oct. 21 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/25/77</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Charles Snitcher</b>		14. MOTHER'S MAIDEN NAME <b>Smith Margaret Colman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> <b>Hospital Records, E.S.S.H., Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/19/59</b> to <b>10/21</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> , 19 <b>61</b> , and that death occurred at <b>8:25 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John F. Schneider</b> M.D.		22b. DATE SIGNED <b>10/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John F. Schneider, M.D.</b>		22d. ADDRESS <b>Easton, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 23, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crumpton Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Crumpton, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward J. Fellows</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 25 '61</b>	
ADDRESS <b>Willington, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>	





11363

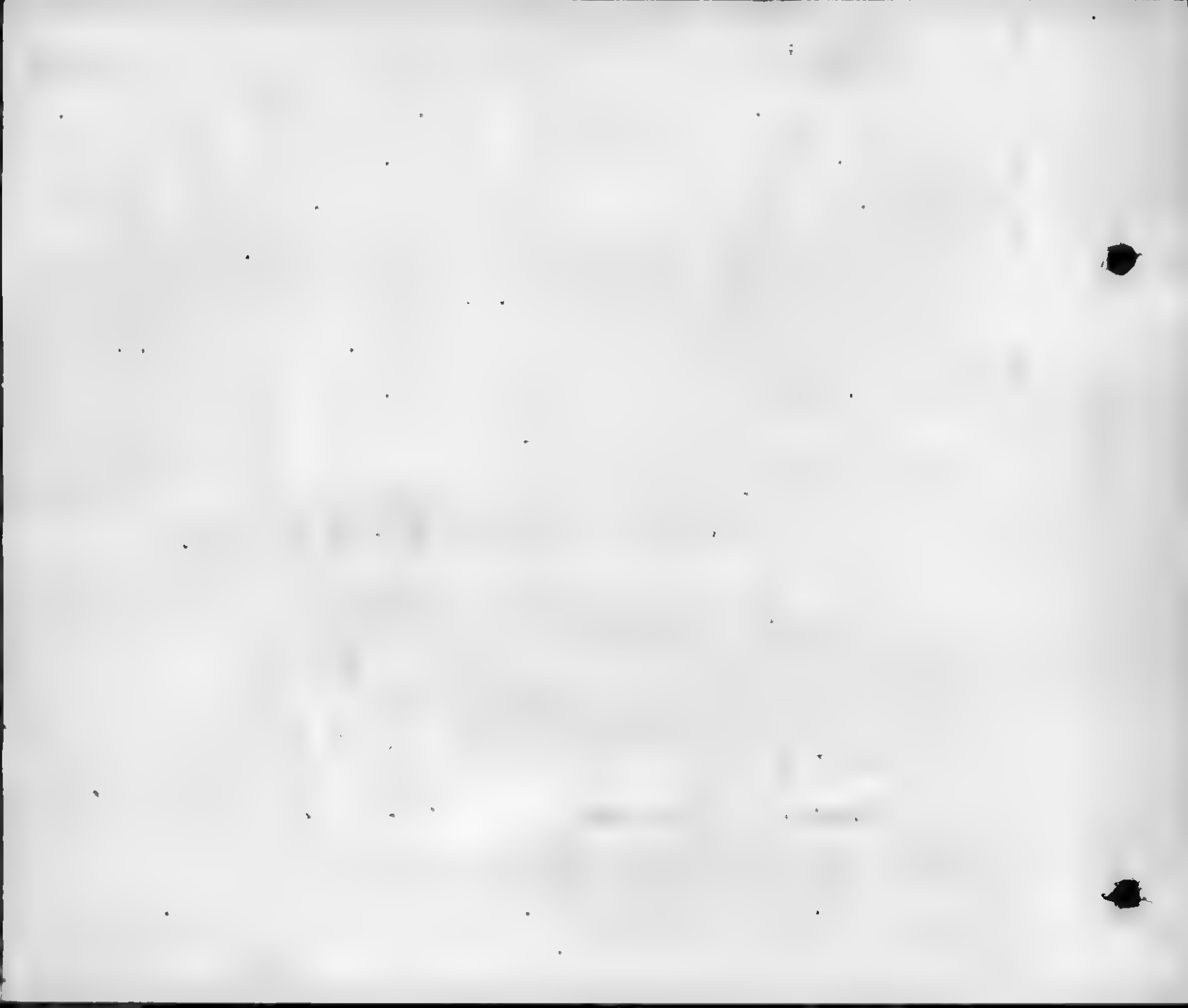
## CERTIFICATE OF DEATH

Reg. Dist. No. 11348

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Cambridge Md. Hospital</b>		d. STREET ADDRESS <b>410 Maryland Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Willey</b> Last <b>Stoker</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>14</b> , Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1889</b>
9. AGE (In years last birthday) <b>72</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Cambridge Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William M. Willey</b>		14. MOTHER'S MAIDEN NAME <b>Emma S. Reid</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Betty Williamson</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral haemorrhage</b> DUE TO <b>442X</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic hypertension CVD.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity, simple.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>?</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 1</b> , 19 <b>61</b> , to <b>Oct 14</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Oct 14</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b> DATE SIGNED <b>10/19/61</b>			
ACTUAL SIGNATURE <b>James L. Thompson</b> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 17, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		ADDRESS <b>Cambridge Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE OCT 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(near) Cambridge, Md.</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>-</b> Last <b>Tawes</b>		4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-88</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>not known Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>not known USA</b>	
13. FATHER'S NAME <b>not known Jesse D. Evans</b>		14. MOTHER'S MAIDEN NAME <b>not known Rachel Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Medical Records-Eastern Shore State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> DUE TO 153-8 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the colon with metastases</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER - NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from <b>October 13, 1961</b> to <b>October 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>Oct. 28, 1961</b> , and that death occurred at <b>5:48 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>John F. Schneider</b> M.D.		22b. ADDRESS <b>"Peachblossom" Easton, Maryland</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John F. Schneider M.D.</b>		22d. DATE <b>October 28, 1961</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Oct. 30, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SHANNON WADGE Crisfield Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield Md</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Harvey Bradshaw</b>		25a. REC'D BY REGISTRAR <b>NOV 2 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Clifton L. Hanna</b>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

11365

11350

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 22x-2			
d. NAME OF HOSPITAL (If not in-hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Quantico Road Rt 5</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Claude Hamilton Taylor</u>				4. DATE OF DEATH Month Day Year <u>Oct 15 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9, 1899</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Farm</u>		11. BIRTHPLACE (State or foreign country) <u>USA MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sidney Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT Address <u>Hospital Records Cambridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____ INTERVAL BETWEEN ONSET AND DEATH <u>UNK</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 3 1959</u> to <u>OCT 15 1961</u> , that (I) (we) last saw the deceased alive on <u>OCT 14 1961</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Thomas J. Dredge</u> M. D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10-15-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>				22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-17-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Taylor Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Funeral Home</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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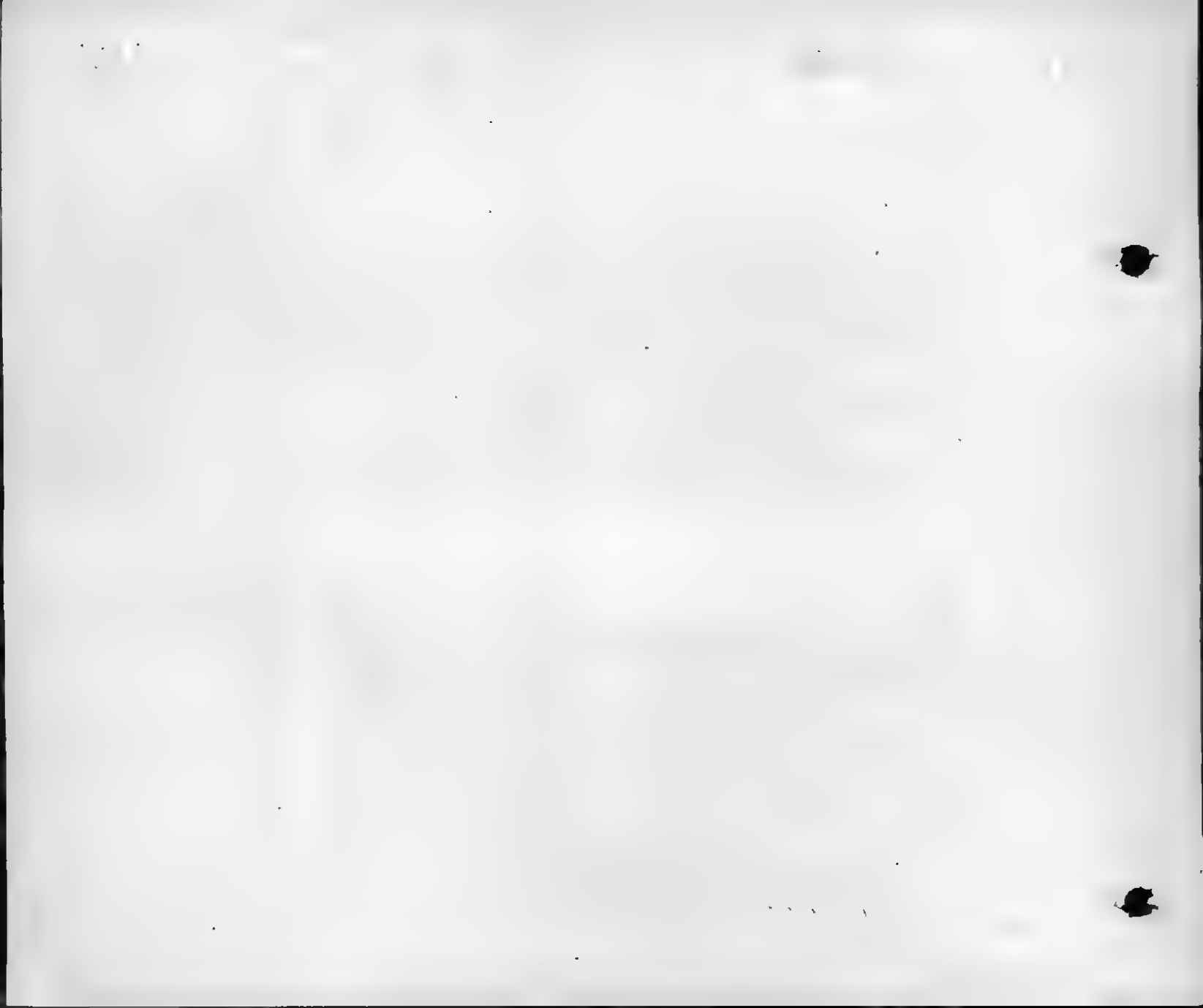
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11366

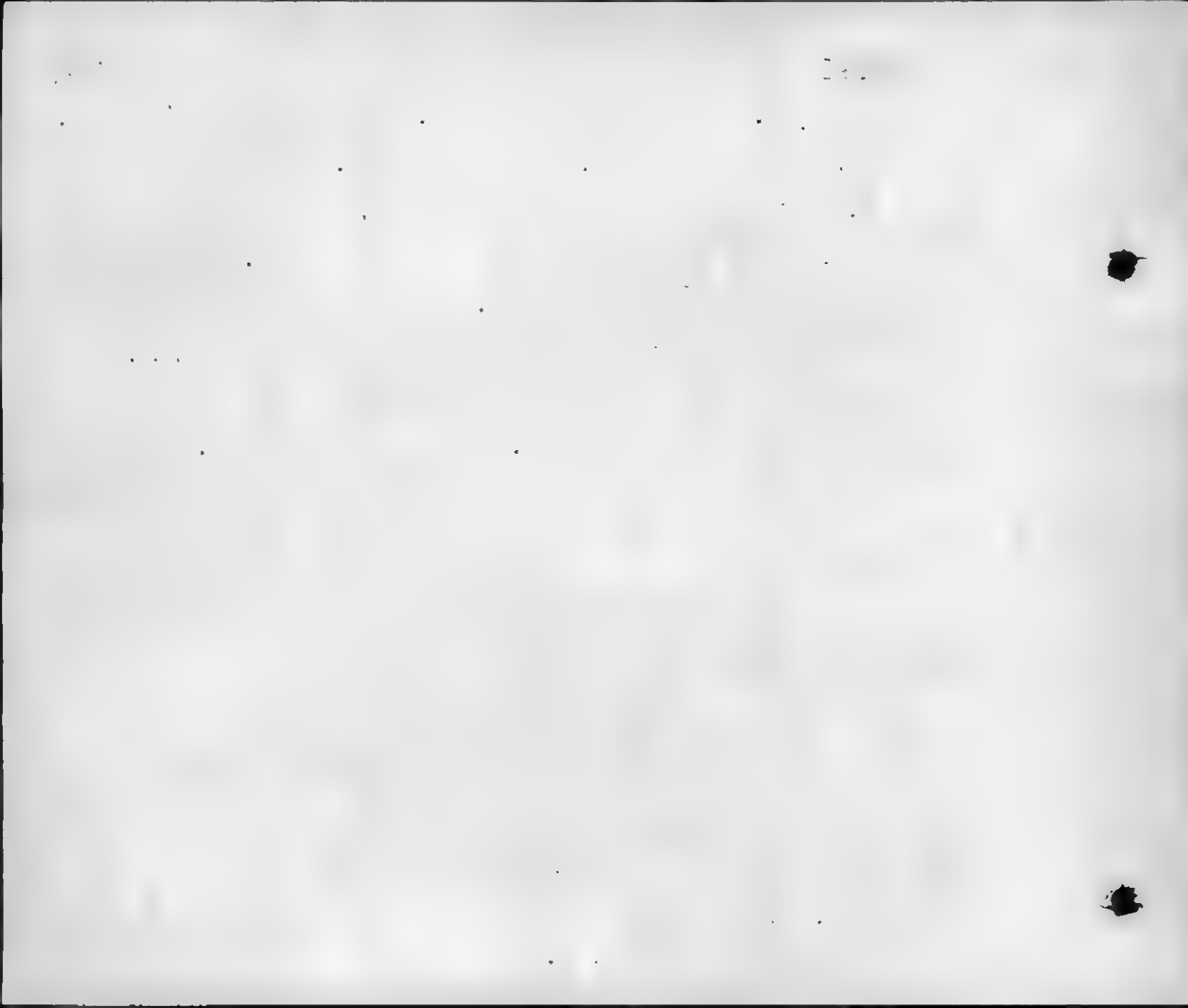
Reg. Dist. No. 11351

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
 1. Write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
 2. Should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 3. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Md.</b>		c. LENGTH OF STAY IN 1b <b>12 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Md. Hospital</b>			d. STREET ADDRESS <b>Bailey Rd.</b>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Kirby</b> Last <b>Towers</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>14</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1887</b>	9. AGE (In years last birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Edward Towers</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Nichols</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Towers Bailey Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY EMBOLUS</b>					
72011 DUE TO					
Conditions, if any, which gave rise to immediate cause (b) DUE TO					
(c) stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSION</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Easton</b>		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Alfred R. Maryanov</b>		M D CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10/16/61</b>	
EXAMINER'S NAME (Type) <b>ALFRED R. MARYANOV</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 16, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Easton</b>		(State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles P. Kline</b>	





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 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

11352

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>5 mo. 23das.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>None</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>-</b> Last <b>Walls</b>				4. DATE OF DEATH Month <b>October</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-26-77</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b>	IF UNDER 24 HRS. Hours <b>84</b> Min. <b>84</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. E. Walls</b>				14. MOTHER'S MAIDEN NAME <b>Etta Phillips</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Laura Walls Ridgely, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis with Cardio-vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>vascular Disease</b> DUE TO (c) <b>vascular Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Sev. yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 28 1961</b> to <b>October 20 1961</b> , that (I) (we) last saw the deceased alive on <b>October 20 1961</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Simon Virkutis</b> M.D.				22b. DATE SIGNED <b>10-20-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Simon Virkutis</b>				22d. ADDRESS <b>E.S.S. Hospital, Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-22-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ridgely</b>		23d. LOCATION (City, town, or county) (State) <b>Ridgely, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Bouleis Jr. Greensboro, Md.</b>				25a. RECEIVED BY REGISTRAR <b>Oct 23 61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>	

1730

## CERTIFICATE OF DEATH

Reg. Dist. No.

11353

11368

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>1 day - 21hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>				e. STREET ADDRESS <b>Cambridge R.F.D. # 2</b>			
3. NAME OF DECEASED (Type or print) First <b>Beverly</b> Middle <b>Jean</b> Last <b>Willey</b>				4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 29 1961</b>		9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>1</b> Days <b>21</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eldridge Mace Willey</b>				14. MOTHER'S MAIDEN NAME <b>Verna Ernestine Wheatly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Verna Willey - Cambridge, Maryland Route #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital skull anomaly</b> <b>758.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 Day 21 Hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>19</b> o. m. p. m.	Month <b>10</b>	Day <b>28</b>	Year <b>1961</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cambridge</b>	(County) <b>Md.</b>
21. I certify that I attended the deceased from <b>10/28</b> , 19 <b>61</b> , to <b>10/30</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>10/30</b> , 19 <b>61</b> , and that death occurred at <b>7:40 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. H. Hanks</b>				ADDRESS (Street, city or town, state) <b>104 Lous ST Cambridge MARYLAND</b>			
DATE SIGNED <b>10/30/61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 1, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Cambridge Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 3 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

11363

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1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Signature of physician: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_

11. Date of registration: \_\_\_\_\_

12. Name of registrar: \_\_\_\_\_

13. Name of physician: \_\_\_\_\_

14. Name of informant: \_\_\_\_\_

15. Address of informant: \_\_\_\_\_

16. Signature of informant: \_\_\_\_\_

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